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**SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC**

# INTERIM TECHNICAL REPORT

## Deliverable 6.2

August 1st, 2016










This report is part of the project '717275 / SH-CAPAC' which has received funding from the European Union's Health Programme (2014-2020). The content of this report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

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# 1 Introduction

CHAFEA and a consortium of seven European institutions coordinated by the Escuela Andaluza de Salud Pública (EASP) signed a grant agreement for a one-year action on December 2015.The action is called '*Supporting heath coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure'* (SH-CAPAC), and was awarded under an EC emergency call for proposals in response to the refugee situation in Europe. The action spans the period comprised between January 1,2016 and December 31st 2016 .The other consortium members are Azienda Unita Sanitaria Locale di Reggio Emilia in Italy, Trnava University in Slovakia, University of Ghent in Belgium, Jagiellonian University in Poland, Copenhagen University in Denmark and Academic Medical Centre of the University of Amsterdam.

This interim report covers the first seven months of implementation of the grant agreement (January to July 2016). A briefing on the salient aspects contained in this report was made to the project officer Paola D'Acapito in Luxemburg, on July 7th in a meeting previous to the CHAFEA /DG Santé project coordination meeting. The report is being posted in the Sygma Platform and a general public version will also be posted in the SH-CAPAC webpage and in the DG Santé Health Policy Portal.

Slight modifications in the wording of the deliverables and milestones of the project to adjust to new realities are included in this report and will be submitted as an amendment to the Grant Agreement even though the nature of the deliverables remains unchanged.

Some conclusions and recommendations are presented at the end of the report. The intention is twofold: a)suggesting possible courses of action for giving continuity to the work of this and other funded projects after the date of conclusion at the end of 2016 and b)providing inputs for the dissemination conference planned by DG Santé/CHAFEA for March 2017.

# 2 Revisions of Deliverables and Milestones

The language of the original Deliverables and Milestones have been slightly adjusted to better reflect the exact nature of the work being conducted. Some adjustments in the due dates of the deliverables and milestones, resulting from the need for incorporating the rich feed-back received from target Member States in the multiple consultations, have been introduced as well. There are no new deliverables nor milestones.

These modifications will be submitted as an amendment to the Grant Agreement. As mentioned before the scope and nature of the deliverables and the milestones remain unchanged.

# SH CAPAC List of deliverables (updated August 1 2016)

| Deliverable number | Deliverable title | WP number | Lead beneficiary | Type | Dissemination level | Due date (in months) |
|---|---|---|---|---|---|---|
| D1.1 | Report on the workshop for the framework for national and regional coordination and coherence(including the final version of the framework) | WP1 | 1 - EASP | Report | Public | 4 |
| D1.2 | Reports on seven technical advice missions to support coordination and coherence | WP1 | 1 - EASP | Report | Public | 12 |
| D2.1 | Report on the combined regional WP2 and WP3 workshop (needs assessment component )including the final version of the Guide for Assessing Health Needs and Health Protection Resources | WP2 | 6 - UCPH | Report | Public | 8 |
| D2.2 | Report on seven technical advice missions to support needs assessments at country level | WP2 | 6 - UCPH | Report | Public | 12 |
| D3.1 | Report on the combined regional WP2 and WP3 workshop (action planning component) including the final version of the Guide for formulating Action Plans | WP3 | 3 - TU | Report | Public | 8 |
| D3.2 | Reports on seven technical advice missions to support action planning at country level | WP3 | 3 - TU | Report | Public | 12 |
| D4.1 | Resource package on ensuring access to health care | WP4 | 2 - AUSL RE | Report | Public | 8 |
| D4.2 | Report on combined WP4 and WP5 workshop (improving access component). | WP4 | 2 - AUSL RE | Report | Public | 8 |
| D5.1 | Design of a training programme on the health response to refugees, asylum seekers and other migrants | WP5 | 1 - EASP | Report | Public | 7 |

| Deliverable number | Deliverable title | WP number | Lead beneficiary | Type | Dissemination level | Due date (in months) |
|---|---|---|---|---|---|---|
| | for health managers health professionals and administrative staff | | | | | |
| D5.2 | Report on Training of Trainers workshop for discussing the adaptation of the training materials and strategy to national and subnational situations | WP5 | 1 - EASP | Report | Public | 10 |
| D5.3 | Report on design, development and evaluation of the online training course | WP5 | 1 - EASP | Report | Public | 12 |
| D6.1 | Work plan of the project (including design of a web site and communication platform) | WP6 | 1 - EASP | Report | Public | 3 |
| D6.2 | Interim technical report | WP6 | 1 - EASP | Report | Public | 8 |
| D6.3 | Final technical and financial report, including a laymen report | WP6 | 1 - EASP | Report | Public | 12 |

## SH-CAPAC List of milestones (Updated August 1 2016)

| Milestone number | Milestone title | WP number | Lead beneficiary | Due date (in months) | Means of verification |
|---|---|---|---|---|---|
| MS1 | Framework for national and regional coordination and coherence of health sector activities addressing the needs of refugees, asylum seekers and other migrants | WP1 | 1 - EASP | 4 | Framework developed for national and regional coordination and coherence. |
| MS2 | Regional workshop on the framework | WP1 | 1 - EASP | 2 | Regional workshop organised with relevant stakeholders. |
| MS3 | Support to MS on health sector coordination mechanisms and platforms through seven country missions | WP1 | 1 - EASP | 12 | Seven country missions to support Member States |
| MS4 | Needs assessment framework to diagnose unmet health needs and gaps in access | WP2 | 6 - UCPH | 8 | Rapid assessment framework developed |

| Milestone number | Milestone title | WP number | Lead beneficiary | Due date (in months) | Means of verification |
|---|---|---|---|---|---|
| MS5 | Combined regional WP2 and WP3 workshop on needs assessment and action planning) (See MS8) | WP2 | 6 - UCPH | 5 | Regional workshop held. |
| MS6 | Support to MS on rapid assessment of health challenges, responses and needed public health interventions through seven country missions | WP2 | 6 - UCPH | 12 | Seven country missions to support Member States |
| MS7 | Framework for the development of action plans to strengthen a country's health system | WP3 | 3 - TU | 8 | Framework prepared for the development of action plans |
| MS8 | Combined regional WP2 and WP3 workshop on rapid assessment and action planning) (See MS5) | WP3 | 3 - TU | 5 | Regional workshop held. |
| MS9 | Support to MS on action planning through seven country missions | WP3 | 3 - TU | 12 | Seven country missions to support Member States |
| MS10 | Resource package to improve access, containing recommendations and action guides | WP4 | 2 - AUSL RE | 8 | Resource package prepared. |
| MS11 | Combined WP4 and WP5 workshop to disseminate the resource package on improving access(See MS13) | WP4 | 2 - AUSL RE | 7 | Workshop held. |
| MS12 | Support the adoption of tools and measures contained in the resource package (7 countries) | WP4 | 2 - AUSL RE | 12 | An analysis prepared of measures and tools adopted in each country. |
| MS13 | Combined WP4 and WP5 workshop to raise awareness of training strategy and training programme (See MS11) | WP5 | 1 - EASP | 7 | Workshop held |
| MS14 | Design of training programme for health managers, health professionals and administrative staff | WP5 | 1 - EASP | 8 | Training programme completed and made available on a virtual campus in the project website. |
| MS15 | Training of Trainers workshop | WP5 | 1 - EASP | 9 | Workshop held. |
| MS16 | Online training course | WP5 | 1 - EASP | 12 | Training course implemented. |
| MS17 | Evaluation of the training course | WP5 | 1 - EASP | 12 | Evaluation report prepared. |
| MS18 | Consortium one day meeting to elaborate the operational work plan and task distribution between partners | WP6 | 1 - EASP | 2 | One day consortium meeting held at EASP, Granada. |

| Milestone number | Milestone title | WP number | Lead beneficiary | Due date (in months) | Means of verification |
|---|---|---|---|---|---|
| MS19 | Consortium and other institutions' one day coordination meeting to ensure that other institutions' strategies are adequately included in the work plan. | WP6 | 1 - EASP | 2 | One day Consortium and other institutions' meeting is held at EASP, Granada. |
| MS20 | Consortium meeting to revise instruments and elaborated products, and follow up the operational plan | WP6 | 1 - EASP | 5 | Consortium meeting held in TU, Slovakia. |
| MS21 | Work plan | WP6 | 1 - EASP | 3 | Work plan prepared and submitted. |
| MS22 | Web design | WP6 | 1 - EASP | 2 | Website designed and active. |
| MS23 | Communication plan | WP6 | 1 - EASP | 2 | Communication plan prepared. |
| MS24 | Interim technical report | WP6 | 1 - EASP | 8 | Interim technical report prepared and submitted. |
| MS25 | Final technical and financial report, including a laymen report | WP6 | 1 - EASP | 12 | Final technical and financial report prepared and submitted. |

# 3 Progress toward achieving deliverables and meeting milestones

The following paragraphs offer a summary, by Work Package, of the salient aspects of each stream of work, of the planned meetings organized and of the deliverables produced between January and July or to be produced in the upcoming five months.

## 3.1 Work Package 1

The Coordination Framework for addressing the health needs of the recent influx of refugees, asylum seekers and other migrants into the European Union Countries (D1.1/MS1). was completed following the inputs received in the Ghent workshop held on February 2016 and the discussions held during the internal consortium meeting in Trnava in April 2016 The framework has been uploaded in the Sygma Platform and the SH-CAPAC webpage (Annex 1). It has been used in the Country support missions.

A regional workshop on effective health sector coordination for addressing health needs of refugees, asylum seekers and other migrants in EU countries was held in Ghent, Belgium on 23-24 February 2016 with the participation of a large number of target Member States (twelve) and other international stakeholders involved in the health response to the large migratory influx. The meeting served as a consultation for further developing a draft Framework for coordination and coherence and as an opportunity to disseminate the SH-CAPAC project and the need for intensifying coordination of all health actors. The final report is available (MS2).

In preparation of the regional workshop a mapping of the response to the health needs of refugees, asylum seekers and other migrants was done. Draft Country Profiles have been prepared by the SH-CAPAC Consortium for each of the 19 target countries of the project Information has been gathered through desk reviews and consultation of multiple sources Drafts have been sent to national health authorities from Member States for review and validation A large number of Country Profiles have been reviewed by country officials and are available in final form. A few more are still being reviewed by Member States. A preliminary analysis of some of the major trends has been completed. The Country profiles are available in the SH-CAPAC webpage.

An umbrella document that provides some background information on the health response to the recent migratory influx into the EU and draws preliminary conclusions from the mapping done has been produced and is available. It has been posted in the SH-CAPAC webpage (Annex 2).

A mission to Bulgaria (Sofia and Haskovo) was conducted at the end of June and beginning of July. A report of the mission is available and will be uploaded in the Sygma Platform as other reports of other missions are completed (Annex 3). The mission permitted to have discussions with multiple national and local stakeholders involved in the health response to refugees and to explore possibilities for improving coordination and coherence in the response.

Upcoming missions to the South Aegean, Greece to Catalonia, Spain, to Slovakia, to The Andalusian Region in Spain to Athens, Greece and to Portugal have been scheduled between the end of August and end of December (D1.2/ MS3).

## 3.2 Work Package 2

An advanced draft of a Guide for Assessment of Health Needs and Available Health Protection Resources is ready (Annex 4). It incorporates inputs received during the workshop held in Copenhagen on May17th and 18th .A final version will be available and posted before December 2016 so the inputs derived from the meeting in Reggio Emilia held on June 16th and 17th and the mission to Bulgaria conducted from June 29th to July 3rd can be incorporated (DS2.1/MS 4).

A regional workshop with the participation of representatives of 10 target Member States was held in Copenhagen on May 16 and 17th. The workshop provided an opportunity to discuss the basic tenets of the Public Health and Health Systems Needs Assessment Framework and Guide and was as well an excellent forum to gather feed-back for the Draft Guide. A report of the workshop is available. An extremely rich feedback derived from the consultation as well as from the subsequent meeting in Reggio Emilia and mission to Bulgaria is being incorporated into the Draft Guide for Assessment of Health Needs and Available Health Protection Resources (MS5).

The missions in connection with the population needs assessment guide comprise the mission to Bulgaria and are being planned for the South Aegean Region in late August and the the Region of Catalonia in Spain ,for the end of September, and several other subsequent missions between September and December (D2.2/MS6).

## 3.3 Work Package 3

An advanced draft of a Framework and Guide for the Development of Action Plans for Implementing a Public Health Response and to Strengthen a Country's Health System in order to address the needs posed by the Influx of refugees, asylum seekers and other migrants is ready (Annex 5). It incorporates inputs received during the abovementioned workshop in Copenhagen. A final version will be available and posted in August 2016 so the inputs derived from the meeting in Reggio Emilia and the mission to Bulgaria can be incorporated (D3.1/MS7).

A regional workshop with the participation of representatives of 10 target Member States was held in Copenhagen on May 16 and 17th.The report of the workshop is available. An extremely rich feedback derived from the consultation is being incorporated into the draft Framework and Guide for the Development of Action Plans for Implementing a Public Health Response and to Strengthen a Country's Health System in order to address the needs posed by the Influx of refugees, asylum seekers and other migrants (MS8).

The first mission in connection with the action plans Framework and Guide took place in Bulgaria .Subsequent missions are being planned to the South Aegean Region in late August and the Region of Catalonia in Spain for the end of September .Additional missions will take place to other countries between October and December 2016 (D3.2/ MS9).

## 3.4 Work Package 4

A draft Resource Package for Ensuring Access to Health Care of Refugees, Asylum seekers and Other Migrants in the European Union Countries has been developed (Annex 6). It identifies a series of barriers for accessing health care and formulates recommendations to overcome those barriers. It was used as the background document for the discussions in the Reggio Emilia workshop. It was based in an ample number of interviews and focus groups conducted in several of the target countries of the project. An extremely valuable feedback was obtained in the Reggio Emilia workshop held in June 2016 and is being incorporated into the Resource Package which will be finalized at the end of August 2016 (D4.1/MS10).

A regional workshop with the participation of numerous representatives of nine target Member States was held in Reggio Emilia, Italy on16$^{th}$-17$^{th}$ June. The objectives of the meeting were :a) to support Member States in promoting and ensuring access to the refugee, asylum seekers and other migrants populations to health care and public health interventions through the development and dissemination of a resource package to reorient local strategies and plans and b)build national capacity through training of trainers in affected countries who can implement training activities for health workers, so they can develop intercultural competences and have a clear understanding of a migrant sensitive health care delivery model, respecting human rights and dignity. The report of the workshop is available. An extremely rich feedback derived from the consultation is being incorporated into the Resource Package (D 4.2/MS 11).

The first mission in connection with the Resource Package for Improving Access took place in Bulgaria and subsequent ones are being is being planned for the South Aegean Region in late August ,for the Region of Catalonia in Spain for the end of September and several other Countries or Regions between October and December (MS 12).

## 3.5 Work Package 5

A regional workshop with the participation of numerous representatives of target Member States was held in Reggio Emilia, Italy 16th-17th June. A draft Training Strategy containing a proposal of training activities to develop refugee/migrant-sensitive health services by training health managers and health professionals and a draft structure of the on-line training program that will be offered by the SH-CAPAC project was circulated and discussed (Annex 7). The report of the workshop is available. An extremely rich feedback derived from the consultation is being incorporated into the draft Training Strategy and the on-line training course (MS13).

A 30 hours on line training course over a period of two months has been designed and the training materials are being developed and will be finalized on August 31st 2016 (D 5.1/MS14) SH-CAPAC will coordinate with the training activities of other CHAFEA funded project, specially EUR-HUMAN to ensure complementarity of efforts.

A Training of Trainers workshop for discussing the adaptation of the training materials and the training strategy to the national and regional situations in targeted Member States will be conducted in Granada, Spain on September 15th and 16th.A detailed report will be produced before the end of October (D5.2/MS15).

The course will be in production in October and November for piloting the materials with participants from the target Member States. The audience will combine health managers, health practitioners and administrative staff, Arrangements are being made for identifying suitable candidates in the respective Member States. (MS16).

The training course evaluation will be conducted at the end of the on-line pilot training course and will be concluded by December 15 2016 (D 5.3/MS17).

## 3.6 Work Package 6

The Inception and coordination meeting of the SH-CAPAC project was held on 14th January in Granada, Spain. The programme and the report of the meeting are available at the SH-CAPAC webpage. It included all Members of the Consortium. The project Officer Paola D'Acapito participated (MS 18).

A meeting with international stakeholders who are part of the health response to refugees, asylum seekers and other migrants was held on 15th January 2016, back to back with the Inception and coordination meeting. It included representation from CHAFEA, IOM, WHO, and ECHO. The programme and the final report are available at the SH-CAPAC webpage (MS19).

An internal consortium meeting with the participation of all Members of the Consortium was held in Trnava, Slovakia on April 8th 2016. The internal workshop permitted a cross fertilization between the different work packages and facilitated the review of the different deliverables to ensure a cohesive approach of the SH_CAPAC activities and products (MS 20).

The work plan was prepared as a result of the inception and kick off meeting in January and was adjusted in April during the Trnava meeting. Final adjustments were made following the meeting with the Project officer in Luxembourg on July 7th (D6.1/MS21).

The SH-CAPAC website (www.easp.es/sh-capac) has been created and is fully operational since February 2016. It is continuously updated. It has a component if internal use for the Members of the Consortium and an external component open to the public for the dissemination of relevant information of the SH-CAPAC project (MS22).

The Communication plan has been elaborated. It is available on the SH-CAPAC website. A brochure on the SH-CAPAC project has been produced and disseminated in all regional workshops or related events (MS23).

The interim technical report covering the period January-July 2016 has been produced and is hereby submitted (D.6.2/MS24).

The final technical and financial report will be delivered as planned at the end of December 2016 (D 6.3/MS25).

# 4 Conclusions and recommendations

The project is progressing satisfactorily and except for the postponement from July to September of the workshop on the training strategy and trainer or trainers, which will take place in Granada, all other meetings and deliverables have been implemented and produced as planned .Financial execution is progressing accordingly and it is anticipated that all the commitments of financial disbursement and program delivery will be accomplished at the end of December.

Having said that it is important to note that the time period for implementing this project is too short and we have had to compress in time tasks and activities that should have been implemented throughout a longer project period.

A major challenge has been to engage Member States, particularly in light of the constant changes in national and European policies in connection with the recent migratory influx including the March 2016 EU Turkey agreement. The SH-CAPAC project has done, as part of its management and coordination, an herculean job in approaching national authorities of the nineteen target Member States, briefing them about the initiative, engaging them in the different regional activities and trying to get them interested in accepting Country support missions. Some of these actions could have been facilitated by a more proactive role of the European Commission informing Member States of the special initiative and of the projects funded.

The real challenge is to give continuity to the efforts and keep the tools, instruments and training materials alive after December 2016. Member States need more time to get familiar with them. EC's action in support to the implementation of what has been produced by SH-CAPAC and by the other four funded projects will be necessary. In this regard DG Sante and CHAFEA should consider the possibility of a joint action in 2017 aimed at giving continuity to the action just initiated during 2016 by the five funded initiatives. The dissemination conference that is foreseen in March 2017 is of great importance and it would be good to start discussions as soon as possible about the scope and purpose of the meeting.

# Annex 1

# Coordination framework for addressing the health needs of the recent influx of refugees, asylum seekers and other migrants into the European Union (EU) countries

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**SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC**

# COORDINATION FRAMEWORK FOR ADDRESSING THE HEALTH NEEDS OF THE RECENT INFLUX OF REFUGEES, ASYLUM SEEKERS AND OTHER MIGRANTS INTO THE EUROPEAN UNION (EU) COUNTRIES

April 21st, 2016










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## User's guide

- The present document aims at supporting individual EU Member States in defining the fundamental elements that ought to be present in a health coordination mechanism for multiple national and international stakeholders. These stakeholders are involved in the response to the health needs of refugees, asylum seekers and other migrants, who are part of the recent influx into the European Union.

- This health coordination framework speaks primarily to national or subnational health authorities. These authorities are responsible for defining an operational strategy to harness the contributions of different actors to the provision of health care and the implementation of public health interventions, addressed to these migrant populations. It is also intended for the different governmental and non-governmental actors, as well as international and civil society organizations, who participate in the national and local efforts, directed at responding to the health needs of these vulnerable populations.

- Flexibility in the application of this health coordination framework is highly recommended. Any ministry/governmental authority can select the parts that are relevant for their country/context and customise them to develop or strengthen their context-specific coordination mechanism.

- The health coordination mechanism aims to ensure that the national and local efforts directed at responding to the health needs of migrant populations fit well into the national health system. It is, however, not the only coordination solution, and may well be part of other forms of (sub)national coordination.

- The health coordination framework was presented at the SH-CAPAC workshop involving representatives of EU Member States on 23 and 24 February 2016 in Ghent, Belgium. It was also discussed at the SH-CAPAC meeting on April 6 2016 in Trnava, Slovakia. The draft has integrated the recommendations from the workshop and meeting. It has also been adjusted to the new circumstances of the migrant flows. Further amendments may be needed in the future. Revisions will be made publicly available on http://www.easp.es/sh-capac/.

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## List of acronyms

| | |
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| BEOC | Basic emergency obstetric care |
| CD | Communicable disease |
| CEOC | Comprehensive emergency obstetric care |
| CESCR | UN Committee on Economic, Social and Cultural Rights |
| ECDC | European Centre for Disease Prevention and Control |
| ECHO | European Community Humanitarian Aid Office |
| EPI | Expanded Programme of Immunization |
| EU | European Union |
| HIV | Human immunodeficiency virus |
| HRH | Human resources for health |
| IASC | Inter-Agency Standing Committee |
| ICCPR | International Covenant on Civil and Political Rights |
| ICESR | International Covenant on Economic, Social and Cultural Rights |
| IEC | Information education communication |
| IFRCRC | International Federation of Red Cross and Red Crescent Societies |
| IOM | International Organization for Migration |
| LHA | Local health authority |
| MdM | Médecins du Monde (Doctors of the World) |
| MI | Ministry of Interior |
| MISP | Minimum Initial Service Package |
| MMA | Ministry of Migration and Asylum |
| MOH | Ministry of Health |
| MS | Member State |
| MSF | Médecins sans Frontières (Doctors without Borders) |
| NCD | Non-communicable disease |
| NGO | Non-governmental organization |
| NHA | National health authority |
| PHC | Primary health care |
| PMTCT | Prevention of mother to child transmission |
| RH | Reproductive health |
| RHA | Regional health authority |
| SGBV | Sexual and gender-based violence |
| SHC | Secondary health care |
| SRH | Sexual and reproductive health |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| THC | Tertiary health care |
| UCPM | (European) Union Civil Protection Mechanism |
| UDHR | Universal Declaration of Human Rights |
| UN | United Nations |
| UNCT | United Nations Country Team |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations International Children's Emergency Fund |
| WASH | Water, sanitation and hygiene |
| WHO | World Health Organization |
| WP | Work package |

## Glossary

➔ **Health coordination framework** is the tool that aims to facilitate the establishment or strengthening of the coordination of the health response to the influx of migrants.

➔ **Health coordination mechanism** is the mechanism set up and lead by the health coordination core team, involving all relevant stakeholders. It is responsible for the various functions of coordinating the health response through the assessment of health needs, strategic and action planning, monitoring and evaluation, advocacy and resource mobilisation.

➔ **Health coordination team** is the core executive team leading the coordination of the health response to the influx of migrants. It is designated by the leading governmental authority/agency providing health care to migrants (from asylum seekers to undocumented migrants).

➔ **Subnational level** refers to the level below the national or central level; it can be the provincial or local municipality level.

# 1 Why do we need a health coordination framework?

The European Union (EU) is at the heart of an expanding range of increased migration streams. This influx brings different types of migrants who can be categorised according to the phase of the migration trajectory they are in and/or the type of residence status they have at that point. The range includes newly arrived migrants, migrants in transit not claiming asylum, asylum seekers, migrants having been granted refugee or protected status and migrants who become or remain undocumented. Each category of migrants comprises people of different gender and ages, including unaccompanied minors.

In most EU Member States (MS), multiple national and international stakeholders are currently involved in the response to the health needs of refugees, asylum seekers and other migrants who are part of the recent population influx into the European region. Improved coordination of all these stakeholders and actors addressing the migrants' health needs results in a strengthened high-quality and comprehensive health response. This health coordination framework is aimed at supporting individual EU MS in defining the fundamental elements that ought to be present in the development of such health coordination.

## 1.1 Rights and entitlements to health

Not all migrants have the same entitlement to health care. Yet, WHO defines health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* (WHO, 1948).

With the Universal Declaration of Human Rights (UDHR, 1948), the *enjoyment of the highest attainable standard of health* was put forward as a fundamental right of every human being. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued "General Comment 14", an authoritative explanation of the Article 12.1 on the right to health of the ICESCR. It states in paragraph 12 (b) that governments have legal obligations to ensure that *"health facilities, goods and services are accessible to all, especially the most vulnerable of marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds"*, defined as *"race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status"* (§18). In addition, the CESCR specified that States have an obligation to respect the right to health *"by refraining from denying or limiting equal access (…) for all persons, including (…) asylum seekers and illegal immigrants, to preventive, curative and rehabilitative health services*". **All 27 EU Member States ratified this "International Bill of Human Rights"** which integrates the human right to health defined in UDHR, ICESCR and ICCPR.

In the EU, the right to health care is also included in the **Charter of Fundamental Rights of the European Union** (Art 35): "*the right to health care includes the right of every person to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws*".

Furthermore, the **European Directive on Minimum Standards for Reception of Asylum Seekers** (2013/33/EU) contains several stipulations on ensuring health care access for asylum seekers and more specifically emergency care and essential treatment of illnesses and of serious mental disorders (Art 19.1), necessary medical and other assistance to applicants with special needs, including mental health care (Art 19.2), assessment of vulnerable persons such as minors who have been victim of torture, rape or other

serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation (Art. 21) and applicants with special needs (Art 22), treatment for victims of sexual and gender-based violence and torture (Art 25.1), minors who have been victim (Art. 23.4) and prevention of SGBV in the reception facilities (Art 18.4).

Besides, EU Member States need to guarantee applicants' subsistence and protection of their physical and mental health (Art. 17.2), ensure adequately trained staff, bound by confidentiality rules (Art 18.7), ensure necessary basic training of staff with respect to both male and female applicants (Art 29.1), and provide free legal assistance (Art. 26.2).

### 1.2 Challenges of the health response to the recent influx of migrants

Refugees, asylum seekers and migrants often require a health response that combines crosscutting issues. These include sexual and reproductive health, including maternal and child health, mental health and psychosocial support, injuries, and sexual and gender-based violence treatment and prevention. The different types of migrants face different health challenges at the different moments of their passing through or stay. They also display health-seeking behaviours that reflect their culture and the access to health care they had in their country of origin. This behaviour is in turn influenced by stress and conditions of the journey, causing some migrants to delay health care.

In addition to these more individual challenges related to the migrants' profiles, there are organisational challenges, such as the availability, accessibility and quality of health services, caregivers' attitude and understanding of the law and bureaucratic barriers. Societal challenges, such as the myriad of entitlements to health care and geopolitical negotiations on a common European approach to the refugee influx. also severely impact the potential health response.

A mapping of the health care response to the recent influx of refugees, asylum seekers and other migrants in 19 European Union Member States[1] until February 2016 demonstrated that the health response so far remains fragmented. The involvement of many different partners, not all acting in harmony, results in overlapping, duplication and unmet health needs. This is due to the lack of adequate coordination both within a Member State and between Member States, as well as at the European level.

### 1.3 Setting the scene for a coordinated health response

The current context requires that prompt action is taken to guarantee health care to all refugees, asylum seekers and other migrants present in the European Union Member States.

Contextual elements to take into account are:

- The crisis is dynamic, influenced by changing politics, seasons and the evolution of major conflicts triggering it. New political agreements, such as the EU-Turkey statement of 18 March 2016 to address the migrant crisis and EU-Turkey cooperation, indicate the need for preparedness to respond rapidly to a changing context. In addition, each European country presents its particularities in terms of culture, governance, and political situation that impact on the response offered.

[1] See report: SH-CAPAC. WP1 – Mapping of the health response. March 2016.

- The EU Member States are dealing with a protracted crisis with increased impact on various local sectors, including health, which is aggravated by insufficient planning of a long-term, integrated multi-sectoral response. The presence of and interaction with international actors can make this response complex and challenging.
- The Member States' legal and policy frameworks do not always alleviate barriers of access to health care. A gap exists between the recognition of the universal right of all to health care and its adherence in several EU Member States.
- Migration in itself is not a health risk, but the migration process can often bring circumstances posing important health risks and challenges.
- Migrants' health goes beyond the traditional management of communicable diseases and is closely linked with the social determinants of health.
- The profile of the displaced population has become very gender and age diverse indicating an increased need for sexual, reproductive and child health services, as well as geriatric care.
- The health needs we are observing are demonstrating a compounded effect of acute critical health needs that warrant humanitarian interventions, as well as health needs that require access to regular comprehensive health care and public health interventions, provided by the countries' health systems.
- Many of these migrants are survivors of different types of violence. Some are victims of physical violence needing prostheses. There are victims of psychological trauma needing specialised treatment. There are others in need of specific clinical, psychosocial and forensic actions in response to sexual violence experiences. Sexual violence is also a specific reason for claiming asylum and a priority health concern. It requires both prevention and response interventions at all stages of migration and in all types of reception facilities.
- A number of migrants have serious chronic conditions (e.g. cancer, diabetes…) whose treatment should be continued.
- Gaps exist in the national health information and disease surveillance systems. These, in turn, increase the risk of vaccine preventable diseases and outbreaks, especially in the crowded conditions of reception or detention centres.
- Sometimes unnecessary mandatory health checks have been imposed in some Member States. The right balance needs to be found between ethics and people's rights versus security pressures.

> *"In spite of a common perception that there is an association between migration and the importation of infectious diseases, there is no systematic association. Communicable diseases are primarily associated with poverty. Refugees and migrants are exposed mainly to the infectious diseases that are common in Europe, independently of migration. The risk that exotic infectious agents such as Ebola virus and Middle Eastern Respiratory coronavirus (MERS-CoV), will be imported in Europe is extremely low, and experience has shown that, when it occurs, it affects regular travellers, tourists or health care workers rather than refugees and migrants."*
>
> Quote from Z. Jakab, WHO regional director for Europe, 2 September 2015. Source: WHO EURO.

In conclusion, the above points emphasise the necessity of a highly flexible, **coordinated response** that anchors migrants' health in a human rights framework and harnesses all partners, stakeholders and goodwill at national, local and municipal level.

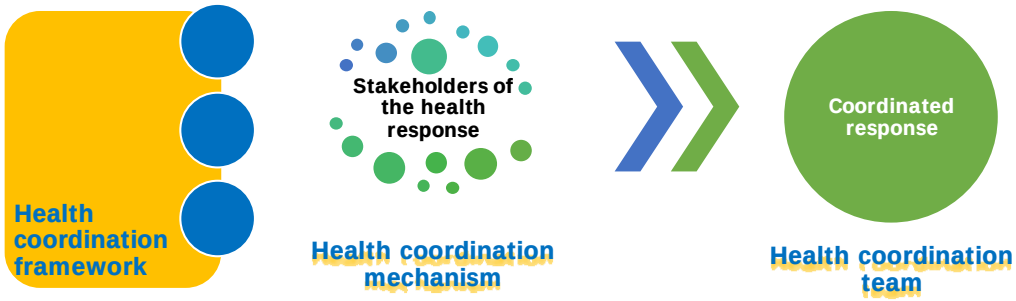
**Improved coordination of all these stakeholders and actors addressing the migrants' health needs results in a strengthened, high-quality and comprehensive health response.**

## 1.4 The aim of this health coordination framework

This health coordination framework aims to provide individual EU Member States with a **tool for strategic guidance** to establish or strengthen a coordination mechanism. Such a coordination mechanism aligns the health response for migrants with the national health system under the leadership of the Ministry in charge (e.g. Ministry of Health, Ministry of Asylum and Migration, Ministry of Interior…).

To this purpose, the health coordination framework provides basic elements for developing or strengthening a health coordination mechanism that brings together all national and international stakeholders involved in the health response to the recent influx of refugees, asylum seekers and other migrants (Figure 1).

**Figure 1: Coordination of the health response**




The purpose of the **health coordination mechanism** is to share information, adopt a coordinated approach, establish common objectives, harmonise efforts and use available (human and financial) resources efficiently to ensure access to appropriate integrated health services for these population segments. An essential element in the functioning of the health coordination mechanism is the appointment of a **health coordination team** that coordinates the response of all stakeholders and actors involved.

When Member States apply this health coordination framework, it will guide them in:

1. Establishing a standing coordination mechanism, led by one of the Ministries or authorities in charge of responding to the health needs of (the recent influx of) refugees, asylum seekers and other migrants *See chapter 2 & chapter 3.2 (1)*

2. Conducting health needs assessments and assessments of the public health response and health care provided to these populations with the participation of the different stakeholders that are part of the coordination mechanism *See chapter 3.2 (2)*

3. Formulating strategies and action plans (including capacity building, preparedness and contingency planning) to respond to the health needs of these populations with the participation of the different stakeholders of the health coordination mechanism *See chapter 3.1 (3)*

4. Mobilizing and coordinating the necessary resources to implement the actions needed for an improved health response *See chapter 3.1 (4)*

5. Monitoring and evaluating the health response to the refugees, asylum seekers and other migrants
*See chapter 3.1 (5)*

6. Leading the communication and advocacy[2] efforts in support of the health response to these populations.
*See chapter 3.1 (6)*

This health coordination framework is part of a set of tools, each one addressing one or several of the elements mentioned above. These tools are being developed in separate work packages (WP) to which reference is made below (see separate documents developed by work packages 2, 3, 4 and 5).

# 2 Health coordination mechanism

The health coordination mechanism is activated up by the Ministries/ authorities in charge of responding to the health needs of different groups of migrants. It involves all relevant stakeholders and is led by a health coordination team. The mechanism aligns the various functions of health needs assessment, strategic and action planning, resource mobilisation, monitoring and evaluation, communication and advocacy with the national health system.

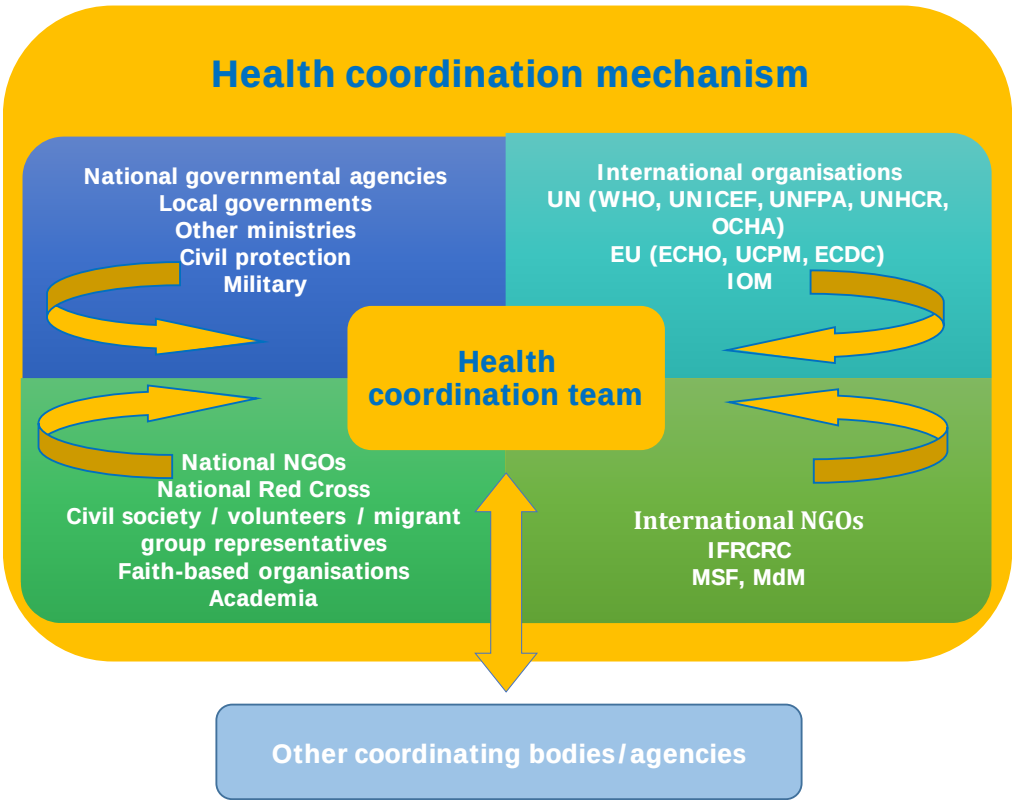
## 2.1 Who should be part of the health coordination mechanism?

The health coordination mechanism brings together all stakeholders involved in the health response to the recent influx of refugees, asylum seekers and other migrants in order to coordinate their actions in a more efficient way. Figure 2 illustrates the potential partners of the health coordination mechanism, but is by no means exhaustive. The national partners are represented on the left hand side. Public services are in the left upper quadrant, whilst the lower left quadrant illustrates the non-public sector at national level, including NGOs and civil society. The right hand side includes the international partners. The UN and EU related organisations are in the upper section and the other international organisations are in the lower portion.

It is highly recommended to encourage a participatory approach and to include representatives of migrant groups in the health coordination mechanism. The efforts of the different actors may thus be more responsive and effective to the (most urgent) needs of the refugees, asylum seekers and migrants.

[2] Advocacy is the deliberate and strategic use of information – by individuals or groups of individuals – to bring about positive change at the local, national and international levels.

**Figure 2: Actors to be involved in the health coordination mechanism**




## 2.2 Type of health coordination mechanism

**Flexibility.** There is no single "one size fits all" approach to the health coordination mechanism. This is because of variations in the context, scale and complexity of the problem across the European countries. In addition, the mechanism must be able to respond to changes in the operating environment. It does so by adjusting requirements, capacity and participation, depending on the national health system and its different levels of involvement/decision making.

Health coordination mechanisms can therefore be applied i) at national level or ii) subnational level, and can focus iii) on internal stakeholders mainly (i.e. different ministries, national agencies, academia…), iv) more on external stakeholders or v) both.

**Importance of subnational coordination.** The subnational coordination mechanisms do not necessarily mirror those at national level. They need to be adapted to the specific context i.e. zones of particular operational importance where multiple partners are operating (especially in arrival countries). This subnational coordination should facilitate decentralised decision-making and shorten response time. Moreover, the response has a better chance to be adapted to local circumstances, and allows for close participation with local authorities and partners. The subnational level should report to the national one, which in turn gives the necessary support. It is important to ensure capacity and seniority at the subnational level.

## 2.3 Activation of the health coordination mechanism


The Ministries/authorities in charge of responding to the health needs of the different migrant groups appoint the health coordination team. They also appoint the team leader/coordinator, who will take responsibility for the coordination of the health response. It is, nevertheless, important to have the Ministry of Health or an equivalent health authority at national or subnational level in the driver's seat, playing a leading role in the health response. Table 1 shows the steps to take into account, when setting up and managing a successful health coordination team.

### Table 1: Enablers for a successful health coordination team

| Process | What | How / Remarks |
|---|---|---|
| **1. Designation of the health coordination team / coordinator** | The authorities in charge of responding to the health needs of different migrant groups designate a health coordination team and coordinator for the health coordination mechanism | The coordinator is ideally supported by other technical public health professionals as per context, e.g. an epidemiologist, a health information specialist and a communication specialist |
| **2. Regular successful meetings** | The health coordinator<br>□ Chairs the meetings of the health coordination mechanism (co-chairing possible)<br>□ Chooses a suitable venue for the meetings<br>□ Sets realistic agenda, with "smart" objectives<br>□ Hands out information before or during the meetings<br>□ Ensures recording of minutes with action sheets (who is responsible for what)<br>□ Keeps meetings short<br>□ Sets date for the next meeting<br>□ Is open to new partners<br>□ Follows up on former agreements | □ Focus on problem solving/action and not just information sharing among members of the health coordination mechanism<br>□ Consider subgroups for specific issues (vaccination campaign, SGBV, mental health…), which report back to the health coordination mechanism meetings |
| **3. Work with other national and international coordinating entities/ working groups** | □ Especially important for cross-cutting issues: SRH, SGBV, mental health, WASH…<br>□ Ensure free flow of information<br>□ WHO can liaise with UNCT, if it is part of the health coordination mechanism | □ Invite representative(s) to the health coordination mechanism meetings<br>□ Designate someone from the health coordination team to attend the respective meetings, as relevant |
| **4. Ensure regular feedback to all involved** | The health coordinator<br>□ Sends out minutes and action sheet within 24-48 hours after the meeting<br>□ Gives regular feedback to the next hierarchical level and other possible partners, who are not part (or only occasionally) of the health coordination mechanism<br>□ Ensures feedback from the next hierarchical level to the coordination mechanism | □ Designates who takes minutes and circulates them. |

# 3 Health coordination team

## 3.1 Composition of the health coordination team

The health coordination team can be organised at national or subnational level, depending on the (geographical) needs and the (de)centralised health system. At each level, the designated leading authority coordinates the process (e.g. Ministry of Health at national level, regional health authority at subnational level). The health coordination team leads and ensures appropriate linkages with all partners involved. These partners may vary according to the country, context and the level, at which the health coordination mechanism is established.

It is suggested to ensure a core group comprised of:

- Coordinator,
- Health information person, and
- Staff member from the health authority with public health experience.

Inclusion of a communication specialist in the health coordination team would be desirable, especially at national level or in a prominent hotspot.

The coordinator is designated by the ministries/authorities in charge of the corresponding level; he or she is someone with proven leadership skills, knowledge of and experience with migrant crisis and with a public health background. The health information person is someone with epidemiological or basic health statistics experience or the staff member/clerk in charge of compiling health data at the local level. An additional staff member with public health experience would be an asset.

Additional persons from the health authority may be called upon to participate in the meeting, depending on the level, contextual needs and dynamics of the situation. An immunisation expert could be called upon for instance, if the need arises for a mass campaign or to inform the various partners of the national routine immunisation norms. At local level, it may be advisable to invite the local hospital director to be part of the core group to ensure smooth referrals and counter referrals.

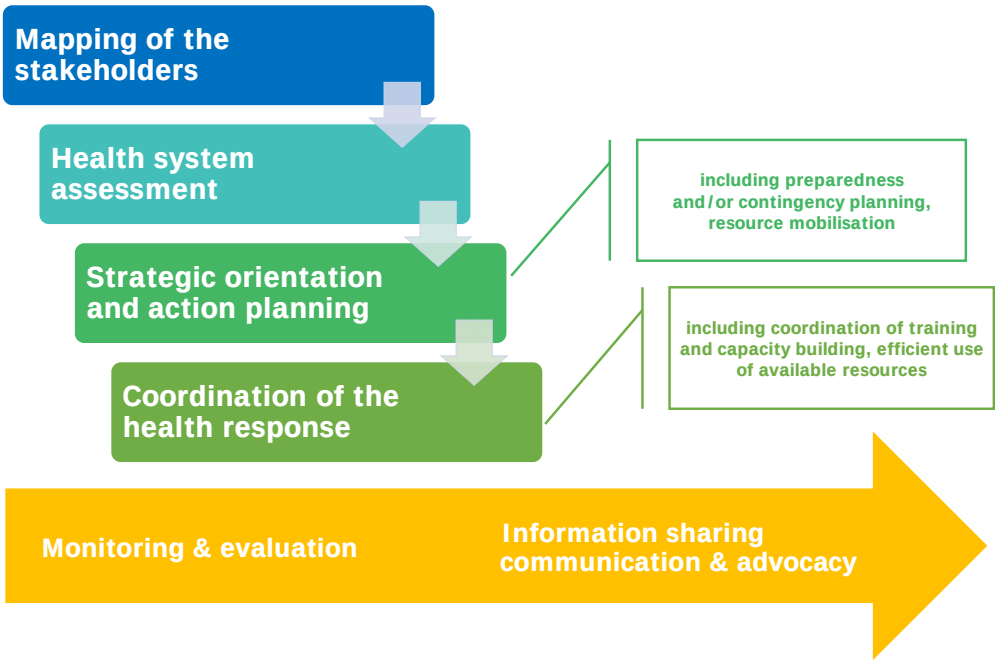
**Basic principles of the health coordination team**

- Comply with values of equity, human rights, gender and cultural sensitivity.
- Ensure commitment and participation.
- Ensure health provision based on health needs.
- Ensure safety, confidentiality, respect and non- discrimination.
- Be inclusive: identify all health actors (including volunteers).
- Complement and strengthen existing coordination structures (make use of what exists already) at national and sub national level (important for hotspots and involvement of regional health authorities). Avoid parallel systems.
- Focus on affected people needs, work at the field level and adopt a result-oriented approach.
- Identify major gaps, problems, barriers, etc., and learn from other similar situations (e.g. neighbouring countries). Learn from errors and mistakes.
- Set realistic objectives based on key priorities, get the buy-in (understand and respect the partners' mandates) and build from there.
- Ensure transparency.
- Give feedback in appropriate language to the concerned populations and the involved stakeholders.

## 3.2 Tasks of the health coordination team

The health coordination team is assigned to perform the tasks depicted in Figure 3.

**Figure 3: Tasks of the health coordination team**




The first four tasks comprise a stepwise process. The mapping of the stakeholders to be included in the health coordination mechanism has to be performed first. This is followed by a health needs assessment so that strategic orientation and action planning can be conducted. Once the coordination starts, the health coordination team has to work in parallel on the efficient and coordinated health response, monitoring and evaluation, information-sharing, communicating and advocating.

### *1) Mapping of the stakeholders*

The health coordination team maps the main (national and international) stakeholders involved in terms of 'Who is doing What Where and When'. It then invites them to be part of the health coordination mechanism. The health coordination team should also link with other coordinating bodies or agencies dealing with non-health sectors that have a direct impact on health. These include agencies dealing with water and sanitation and food security, as well as those who have common programs, such as SGBV, but are not partners of the team. This is important to avoid duplication and ensure complementarities of other stakeholders' efforts.

| WHO? | WHAT? | HOW? |
|---|---|---|
| Health coordination team | ☐ Identify local and international actors<br>☐ Map who is doing what and where<br>☐ Conduct a simplified resource mapping exercise in order to have a rough estimate of the available financial and human resources<br>☐ Understand their mandates, expectations and constraints<br>☐ Gather information, guidelines and tools | ☐ Gather info through use of simple form or round table talk (especially at local level where resources are scarce)<br>☐ Consider use of a tool: e.g.<br>o WHO assessment |

## *2) Health system assessment*

The following elements need to be taken into consideration, when planning a health needs assessment for subsequent strategic orientation and action planning:

1) Access
   - to health services
   - opening hours, especially for women and girls
   - communication (interpreters, pictograms, local facilitators)
2) Staff
   - availability of female and male staff, local staff?
   - training in culturally sensitive communication
   - training in specific areas, such as SGBV and psychosocial support
3) Safety and confidentiality
   - private consultation rooms
   - professional confidentiality
   - women and child friendly safe spaces (especially for unaccompanied minors)
   - security personnel
   - provision of legal advice and protection
4) Risk reduction (can be initiated immediately without assessment)
   - WASH: provision of appropriate water and sanitation taking into consideration the gender perspective
   - appropriate lighting in facilities, especially sanitary
   - presence of Minimal Initial Services Package (MISP) at facilities
   - application of SGBV guidelines
5) Environment
   - community awareness/education programs/public information campaigns
   - use of local field workers

6) Services
   - type of services available, including referrals
   - specific attention to services for reproductive health, including BEOC, SGBV
   - vaccination according to norms [emphasis on measles, mumps, rubella (MMR) and polio]
   - screening for CD as per country of origin
   - surveillance, especially TB
   - psychosocial support
   - care for unaccompanied minors
7) Information management (collect data for action)
   - data collection disaggregated by age and sex
   - identification of vulnerable populations
   - data analysis at local and central level for decision making
   - data management and reporting format
   - respect of confidentiality
8) Financial and human resources
   - funding source: where does the funding come from? (e.g. government, UN, EU, NGO, volunteers. etc/)
   - funding mechanism: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out of pocket expenditures, third payer mechanism, contingency budget
   - funding amount: amount spent on health care responses in Euros, per year/per month; pledged amount if available
   - human resources for health: number of staff by category/specialty
9) Existence of "what would happen if" scenario (e.g. sudden surge) and level of preparedness.

| WHO? | WHAT? | HOW? |
|---|---|---|
| Health coordination team with stakeholders | ☐ Needs assessment<br>☐ Gap analysis and identification | ☐ **See guidance provided by the SH-CAPAC health assessment guide** |

## *3) Strategic orientation and action planning*

When embarking on strategic planning and development of action plans, attention needs to be paid to:

- Coordination of strategic planning with attention to cross cutting issues, such as SRH+ SGBV, mental health, and filling gaps.
- Development of action plans to respond to the health needs identified.

- Development of preparedness[3] plans to deal with surge capacity. This includes contingency planning; communication strategy, including risk communication and internal communication with call lists including other sectors; coordination with the military; pre-positioning of supplies, fixed or mobile infrastructures.
- Coordination of contingency planning for protracted situations, aiming at adopting a health systems approach.
- Application of standards; ensure use of national policies, norms and standards (support development/revision of guidelines, if needed, using recognised international best practices).
- Resource mobilisation (financial, human resources, supplies).
- Planning of capacity building and training in identified priority areas.

| WHO? | WHAT? | HOW? |
|---|---|---|
| HCT with stakeholders and specific national technical staff | Strategic plan<br>Action plan<br>Preparedness and contingency plan<br>Respect of norms and standards<br>Capacity building and training | **For planning: see guidance provided by SH-CAPAC action plan**<br>**For capacity building: see guidance provided by SH-CAPAC resource package and training** |

# Annex 2

# Addressing the health needs of refugees, asylum seekers and other migrants into the European Union countries (umbrella document)

Co-funded by
the Health Programme
of the European Union

**SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC**

# ADDRESSING THE HEALTH NEEDS OF REFUGEES, ASYLUM SEEKERS AND OTHER MIGRANTS INTO THE EUROPEAN UNION COUNTRIES

## *SOME BACKGROUND INFORMATION*

*Working document*

June 6, 2016













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## List of acronyms

| | |
|---|---|
| CESCR | UN Committee on Economic, Social and Cultural Rights |
| EU | European Union |
| ICESR | International Covenant on Economic, Social and Cultural Rights |
| IOM | International Organization for Migration |
| MdM | Médecins du Monde (Doctors of the World) |
| MS | Member State |
| MSF | Médecins sans Frontières (Doctors without Borders) |
| NGO | Non-governmental organization |
| UDHR | Universal Declaration of Human Rights |
| UNHCR | United Nations High Commissioner for Refugees |
| WHO | World Health Organization |

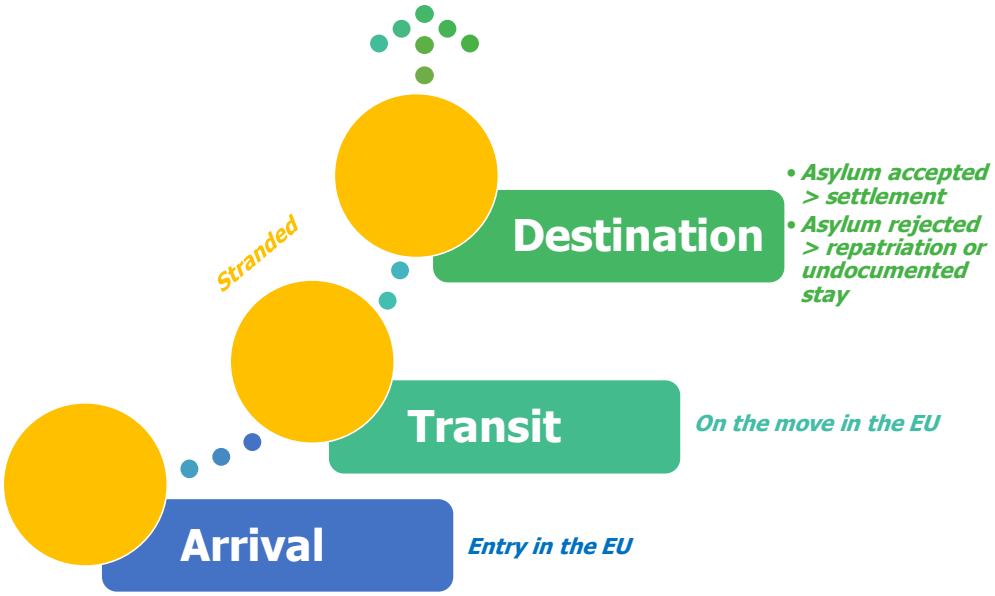
# 1 The recent influx: a complex situation of diverse groups and migratory trajectories

The European Union is at the heart of an expanding range of increased migration streams. This influx generates the presence of different types of migrants who can be categorised according to the phase of the migration trajectory they are in and/or the type of residence status they have at that point (see annex 1 for sources consulted). This ranges from newly arrived migrants, migrants in transit not claiming asylum, asylum seekers, migrants having been granted refugee or protected status, migrants who strand on their journey and migrant who become and remain undocumented. Each category of migrants comprises people of different gender and ages, including unaccompanied minors.

## 1.1 Variations in the migratory trajectory

Many migrants of the current influx arrive in one of the 'first entry' EU countries but continue their journey to their preferred country of destination which is chosen by refugees and asylum seekers themselves, or by those transporting them. Figure 1 shows the different stages of the migration trajectory. Concepts as **arrival, transit and destination** are not clear cut and they offer a lot of grey zones both from migrants and countries, i.e. depending on circumstances a group of migrants may change of being in transit to be stranded. The legal status linked to the migration trajectory stage as well as to the outcome of the asylum seeking procedure play an essential role in migrant's access to health care.

**Figure 1: Migratory trajectory**




Many arriving have to survive an arduous journey involving smuggling, exploitation, crossing deserts, mountains, seas and unfriendly European nations. At a rough estimate there might be 50.000-100.000 people "on the move" at any one time. The legal status of these migrants is usually precarious. As unauthorised entrants they are in principle 'irregular migrants'. In some countries unauthorised entry is a criminal offence, in others only an administrative one. However, article 31 of the 1951 Geneva

Convention prohibits imposing penalties on such migrants "provided they present themselves without delay to the authorities and show good cause for their illegal entry or presence". Countries vary greatly in the way this article is implemented. As soon as migrants apply for asylum, their presence in the country becomes legal; but if they then move on to other countries, it is likely to become irregular again.

It seems likely that the chance of obtaining international protection, the conditions of asylum, the presence of relatives and ethnic networks, the language, and likely future prospects all play a role in deciding upon the destination country. This may change when a compulsory system of redistribution is put in place. Asylum seekers and other migrants at their destination eventually acquire protected status, become (or remain) undocumented migrants, or – less commonly – return home. This group will merge with migrants already in the country.

Although "migrants on the move" are a different target group from "migrants at their destination", the same country may harbour both. There are also liminal situations between these phases. Between "being on the move" and "becoming an asylum seeker" there may a period of administrative limbo in which migrants have been admitted to the country but not to the asylum procedure (e.g. Germany's asylum system has a backlog of hundreds of thousands.) An asylum seeker may be granted protected status but still be unable to integrate into the host society because of lack of housing outside the asylum seeker centre.

## 1.2 Characteristics of the recent influx of refugees and asylum seekers into the EU

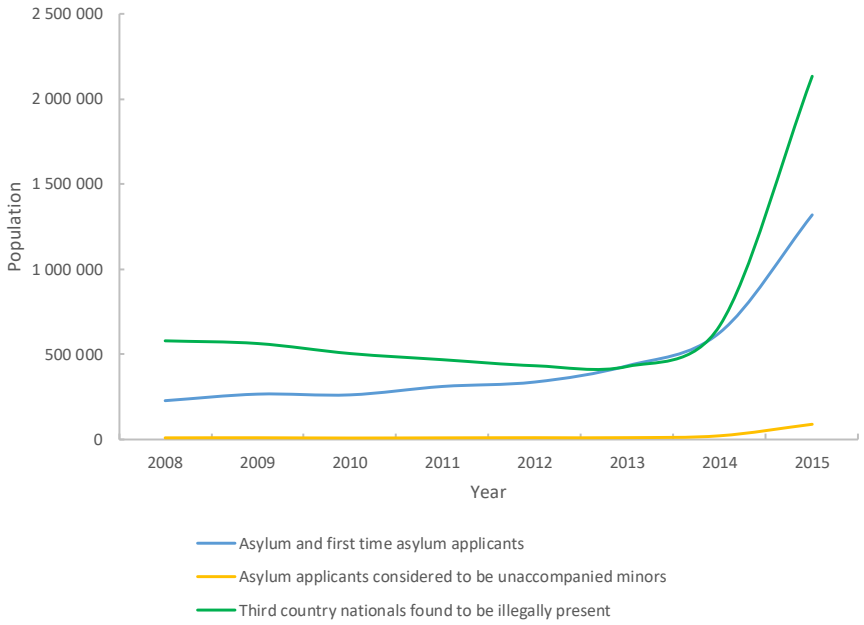
It is important to note that the current influx consists of migrants who, in most phases of their journey, lack authorisation for their entry into or residence in a country. Their legal situation is very different from that of the 51 million other 'regular' migrants already residing in the EU (17 million EU migrants and 34 million third country nationals).[1] The number of third country nationals found to be illegally present in EU Member States was estimated to be around 2,1 million in 2015 (Figure 2).

Up to 2012 a gradual increase in the number of asylum applicants can be noted within the EU, after which the number of asylum seekers rose to 431.000 in 2013, 627.000 in 2014 and close to 1.3 million in 2015 (Figure 2). The five largest groups of first time asylum applicants by citizenship were: Syrians, Afghan, Albanians, Kosovans and Iraqis. Eighty-three per cent of the first time asylum seekers in the EU-28 in 2015 were less than 35 years old, with nearly 3 in 10 applicants were minors aged less than 18 years old. Thus, more than 88.000 of the asylum applicants are considered to be unaccompanied minors (Figure 2). The distribution of first time asylum applicants by sex shows that more men than women were seeking asylum last year. Among the younger age groups, males accounted for 55 % of the total number of applicants. In 2015, fifty-two per cent of first instance asylum decisions in the EU-28 resulted in positive outcomes (i.e. refugee or subsidiary protection status granted), or in an authorisation to stay for humanitarian reasons. With fourteen per cent the share of positive final decisions based on appeal or review was considerably lower.[2]

[1] Source: http://ec.europa.eu/eurostat/statistics-explained/index.php/Migration_and_migrant_population_statistics

[2] Source: http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics

**Figure 2: Evolution of asylum applicants into European Union**




*Source:* EUROSTAT (2016). Statistics 6 June 2016. http://ec.europea.eu/eurostat.

In the last months the number of arrivals has dropped in most EU Member States, but remains high compared to the same period in 2015. The decrease is mainly due to deal agreed between the EU and Turkey whereby irregular immigrants to the EU would be turned back to Turkey, in exchange for increased support for the migrant response in Turkey.[3]

## 1.3 Variations between EU Member States

Based on the above migration trajectory, European countries can be divided into two categories: (1) entry and transit countries and (2) destination countries, with largely different legal situations as result for the migrants (Table 1).

**Table 1: Categories of countries and corresponding legal status of migrants**

| **(1) Arrival and transit countries** |
|---|
| **Arrival countries** most affected are Greece and Italy, but changing political circumstances and seasonal variations can lead to shifts in migration routes. Greece is having to shoulder the burden of accommodating and caring for large numbers of migrants, including providing them with health care. Most migrants travel northwards if they can. Many remain, however, so Greece faces a large increase in numbers of asylum seekers, as well as irregular migrants.<br><br>**Transit countries** are characterized by a large influx, but at the same time a large outflow of migrants, and can be placed under great – but temporary – strain. Only immediate and stopgap forms of health care – first aid – can be administered to migrants in transit, unless they are so incapacitated that they are unable to travel further. Transit countries currently include Greece, Croatia, Slovenia and Austria. The Baltic States and Poland have long been transit countries for migrants arriving via Russia. Belgium, France, Germany and Denmark may be transit countries for migrants trying to reach the UK and Sweden respectively. |

[3] Source: http://www.acaps.org/themes/refugeemigrant-crisis

| (2) Destination countries |
| --- |
| **Traditional destination countries** tend to be relatively wealthy countries with a history of granting asylum such as Sweden, Germany, the UK, Belgium and the Netherlands. The migratory pressure experienced by these countries can be considerable, but it is of a different kind to those described above. In several of the destination countries listed, reception and accommodation facilities (including health services) have already reached or exceeded the limit of their capacity. These countries may be familiar with the typical health needs of asylum seekers, but unable to meet them adequately because of restrictions on entitlement, poor accessibility of services and inadequate resources for overcoming linguistic and cultural barriers.<br>**New destination countries** are experiencing an increase in asylum applications and numbers of irregular migrants but with few previous experience of providing asylum. Most of these countries are in Eastern Europe, but Spain and Portugal also fall in this category. Such countries have in the past received extremely small numbers of asylum seekers. They are now faced with the problem of scaling-up provisions and acquiring new skills and resources. |

## 1.4 Health needs during migratory trajectory

The large numbers of people arriving in and migrating though Europe have different backgrounds, are in different physical, mental and social conditions, and positioned differently in terms of (e.g.) gender, age, educational level and socioeconomic status. The health problems they experience and health risks they are exposed to differ in kind and degree, calling for an *intersectional rather than a generalising approach* to analyse the problems in each phase.

There is nothing new about the health needs of these groups: quite a lot is known already about their needs and the services available, the only thing new is the large recent increase in their numbers in certain countries and to some extent the composition of the groups which affects the patterns of their health needs.

*Intersectionality recognizes that individuals and groups are shaped by multiple and intersecting identities. These identities often inform an individual's world view, perspective and relationship to others in society. An intersectional perspective or framework encourages policymakers and social change leaders to identify the ways in which race, class, gender, ethnicity, sexual orientation, ability and status influence public policy outcomes at the national, state and local levels. This approach can also inform advocacy efforts aimed at increasing equity and equality in society.*

Their health needs are notwithstanding considered an issue of public health importance. The deteriorated purchasing power of these population groups, among others things, leads to rising malnutrition rates. Their access to care other than emergency care is limited. Gaps exist in the national health information and disease surveillance systems. These, in turn, increase the risk of vaccine preventable diseases and epidemic outbreaks. Hundreds of thousands of children should keep on track with their vaccination schedule. The profile of the displaced population indicates an increased need for sexual, reproductive and child health services, as well as geriatric care. Sexual violence is also a specific reason for claiming asylum and a priority health concern, which requires specific interventions. Many of these migrants are survivors of violence and have serious medical conditions. Some are amputees needing prostheses, victims of trauma needing specialized treatment or cancer patients. Hence the health needs observed are *a compounded effect of acute critical health needs that warrant humanitarian interventions as well as health needs that require access to regular comprehensive health care and public health interventions provided by the countries' health systems.*

Health needs change and accumulate during the trajectory of flight/migration. This means, first of all, that it is important to address health needs according to their context 1) across the countries (countries of first arrival/transit and destination countries) and 2) within each country according to which step of the trajectory of flight the assessment concerns (arrival, asylum process, settlement). Secondly, it means that awareness of the cumulative effect of health needs during this trajectory calls for early and coordinated specialized action: vulnerable groups may become increasingly vulnerable during flight. Thirdly, it means that health protection during the final stages of a flight/migration trajectory must be targeted based on the complexity of (physical, psychological and social) unmet health needs that have arisen (and potentially keep rising) during the trajectory.

# 2 Access to health for refugees, asylum seekers and migrants

## 2.1 Rights and entitlements to health

Not all migrants have the same entitlement to health care. Yet, WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948).

With the Universal Declaration of Human Rights (UDHR, 1948), the *enjoyment of the highest attainable standard of health* was put forward as a fundamental right of every human being. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued "General Comment 14", an authoritative explanation of the Article 12.1 on the right to health of the ICESCR. It states in paragraph 12 (b) that governments have legal obligations to ensure that *"health facilities, goods and services are accessible to all, especially the most vulnerable of marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds"*, defined as *"race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status"* (§18). In addition, the CESCR specified that States have an obligation to respect the right to health *"by refraining from denying or limiting equal access (…) for all persons, including (…) asylum seekers and illegal immigrants, to preventive, curative and rehabilitative health services*". **All 27 EU Member States ratified this "International Bill of Human Rights"** which integrates the human right to health defined in UDHR, ICESCR and ICCPR).

In the EU, the right to health care is also included in the **Charter of Fundamental Rights of the European Union** (Art 35): "the right to health care includes the right of every person to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws". Furthermore, the **European Directive on Minimum Standards for Reception of Asylum Seekers** (2013/33/EU) contains several stipulations on ensuring health care access for asylum seekers and more specifically emergency care and essential treatment of illnesses and of serious mental disorders (Art 19.1), necessary medical and other assistance to applicants with special needs, including mental health care (Art 19.2), assessment of vulnerable persons such as minors who have been victim of torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation (Art. 21) and applicants with special needs (Art 22), treatment for victims of sexual and gender-based violence and torture (Art 25.1), minors who have been victim (Art. 23.4) and

prevention of sexual and gender-based violence in the reception facilities (Art 18.4). Besides, EU Member States need to guarantee applicants' subsistence and protection of their physical and mental health (Art. 17.2), ensure adequately trained staff, bound by confidentiality rules (Art 18.7), ensure necessary basic training of staff with respect to both male and female applicants (Art 29.1), and provide free legal assistance (Art. 26.2).

**Mapping of the health response**

In preparation of the development of a health coordination framework, a mapping exercise was conducted of the health care response to the recent influx of refugees, asylum seekers and other migrants. Health representatives from nineteen European Union (EU) Member States were approached in January-February 2016 to update or complete a prefilled profile of their country describing the influx, the type of first assistance services provided, the existence of a health coordination mechanism and the involvement of key actors in provision of health services (see template in annex 2). Twelve countries returned an updated profile: Austria, Belgium, Bulgaria, Croatia, Denmark, Greece, Malta, the Netherlands, Poland, Portugal, Romania, and Slovakia.

The mapping exercise has thus informed the development of a set of frameworks and tools which address the need for a coordinated health response, help to conduct needs assessments, support the planning of appropriate actions, and provide resource packages increase access to health care and training for more culturally-sensitive services. These frameworks and tools can be consulted as stand-alone guidance documents.

## 2.2 First entry assistance services

Analysis of the twelve completed country profiles shows that most countries provide primary health care in reception and/or registration facilities which are governed by national, regional or local governments, through their Ministry of Health, Ministry of Interior, Ministry of Foreign Affairs, the police or the army. In some countries (e.g. Romania), all migrants are registered and screened for their health condition and infectious diseases, giving treatment according to their needs.

In arrival countries (e.g. Greece) NGOs provide a health card/booklet and first aid to refugees, including hygiene and/or health kits. Their first entry assistance includes basic medication for non-communicable diseases and a wide range of services such as screening for serious health problems, curative clinical care (mobile or stationary), clinical management of sexual and gender-based violence. In case of serious life-threatening conditions, referral to hospitals is made or emergency care is provided under national regulations and standards, e.g. for comprehensive emergency obstetric care, in countries such as Romania and Slovakia. Ambulance services are usually available and accessible. In some countries (e.g. Romania) IOM provides subsequent non-emergency medical assistance until the protection status of the refugees and asylum seekers is confirmed by the immigration authorities. Some NGOs provide basic health care services to the refugees at the entry points.

First assistance services in destination countries (e.g. Belgium, Denmark, the Netherlands) often include accommodation, clothes and hygiene parcels, medical and psychological screenings, health care and psychosocial support, childcare, vocational training, and various volunteer-based activities.

## 2.3 Health services provided: where, what and who?

### 2.3.1 Health services provided in arrival and transit countries

Table 2 shows that many actors provide services for people arriving in European countries (e.g. Greece, Italy) after a long journey of travel and migration: IOM, UNHCR, national ministries, international NGOS such as Red Cross, MdM, MSF, and civil society and volunteer organisations. Many of these organisations were/are also active in the transit countries, e.g. Bulgaria, Croatia, and Slovakia.

Some countries have restricted access to health care for those arriving without legal authorisation, but most arrival and entry countries provide a basic health package of primary standard health care, with referrals to secondary or tertiary health facilities in case of severe health risk. In Romania e.g. IOM provides health care services at the Emergency Transit Centre in Timisoara.

IOM interpreters are available upon request to support the migrants and refugees. The interpreters also assist during medical interventions (e.g. in the transit winter centre in Slavonski Brod in Croatia last winter and/or in local hospitals).

**Table 2: Location, type and key actors of the health response in arrival and transit countries**

| WHERE?<br>Location of response | WHAT?<br>Type of health response | WHO?<br>Key actors in the health response |
|---|---|---|
| **Recent arrivals** | | |
| Mainly in reception, accommodation or detention centres, managed by governments or Red Cross | Sometimes first basic medical screening at the dock (i.c. Greece)<br><br>Psychosocial support<br><br>Primary standard health care, with referrals to secondary or tertiary health facilities in case of severe health risk (emergency rooms available in some centres)<br><br>Specialised medical healthcare for babies and children (NGOs)<br><br>Interpreters | Red Cross<br>NGOs<br>IOM<br>UNHCR<br>Civil society organisations<br>Volunteers<br><br>(NGOs)<br><br>(IOM) |
| **People in transit** | | |
| Mainly in reception facilities<br>Hospitals (i.c. in emergency rooms) | Ambulatory care<br><br>Primary standard health care, with referrals to secondary or tertiary health facilities in case of severe health risk (emergency rooms available in some centres) | Red Cross<br>NGOs |

Many migrants with chronic conditions do not have health booklets with them which makes prompt treatment often challenging.

### 2.3.2 Health services provided in destination countries

Although some countries restrict access to health care for asylum seekers, the 'traditional' destination countries provide primary, secondary, tertiary health care as they do for their citizens or residents. In general, children get more and easier access than adults. For undocumented migrants access to health care is sometimes restricted, e.g. Portugal only provides urgent medical care, maternal, reproductive and child care, immunization and treatment of communicable diseases that pose a danger to public health. Undocumented migrants therefore often experience unmet health care needs, often also caused by lack of awareness regarding entitlements of undocumented migrants among health professionals, like e.g. Belgium where undocumented migrants are entitled to preventive and curative care but where health care provider interpret this 'urgent medical care' in a strict (emergency) sense.

NGOs, professional associations, international organisations such as MdM, Red Cross, IOM, UNHCR… are usually the ones giving assistance to newcomers in several countries.

**Table 3: Location, type and key actors of the health response in destination countries**

| WHERE?<br>Location of response | WHAT?<br>Type of health response | WHO?<br>Key actors in the health response |
|---|---|---|
| **Asylum seekers & refugees granted status** | | |
| ○ Reception facilities (collective centres)<br>○ Emergency rooms<br>○ Hospitals | ○ Basic health package of primary, secondary, tertiary, health care, with exceptions and restrictions in some countries (xxx) | ○ National/local government<br>○ NGOs |
| **Undocumented migrants** | | |
| ○ Primary health care centres and hospitals<br>○ Emergency rooms | ○ 'Standard' health provision, mainly ambulatory<br>○ Sometimes limited choice of health care provider<br>○ Sometimes restricted access for specific screening and treatment | ○ Ministry of Health/Regional or local health authority<br>○ NGO<br>○ Red Cross |

Some countries offer welcome / reception facilities for **unaccompanied minors** and give them the right to access health care as children with the nationality of their country. Other countries restrict health services to unaccompanied minors until age assessment has been performed and asylum procedure started.

## 2.4 Challenges for health service providers

Refugees and asylum seekers often require a health response that combines crosscutting issues such as sexual and reproductive health including maternal and child health, mental health and psychosocial support, injuries, and sexual and gender-based violence treatment and prevention. The different types of migrants not only face different health challenges, at the different moments of their passing through or stay, they also display health-seeking behaviours that reflect their culture and the access to health care they had in their country of origin. This behaviour is in turn influenced by stress and conditions of the journey causing some migrants to delay health care.

In addition to the mapping exercise, and in order to gather information on the new challenges for health services related to the current refugee influx, a series of **interviews and focus group discussions** have been conducted in 10 EU countries between February and March 2016.

The major findings of the interviews and focus groups discussions were:

- Delivery of health care to migrants is seriously hampered by the complexity of legal and administrative procedures that have to be executed to guarantee access to care. Care providers are insufficiently familiar with rules that apply, some of them act randomly. Some restrictions exist, some payments are required for certain services and some treatments and drugs cannot be prescribed;
- Linguistic and cultural barriers are systematically identified as one of the major challenges. In many Member States no or insufficient professional interpreters or intercultural mediators are available. Care is often provided on the basis of poor communication and understanding of cultural differences;
- Lack of health records hampers the continuity of care. No adequate systems for exchange of medical information between EU Member States exist. It is often impossible to trace patients in movement from one country to another;
- Living conditions in the arrival camps were criticized. Because of the economic crisis in Greece, hospitals have limited resources to provide pamper, food and clothes to the patients. In countries were a lot of care is provided by NGOs the quality of care may vary;
- Lack of organization, abundance of NGOs, lack of knowledge on cultural differences and media pressure have created unjustified fears among native citizens, particularly where health resources were limited or underfunded;
- Even though most of migrants do not suffer severe health problems (with the exception of some arrivals to the shorelines), health professionals have to be alert to recognize the few cases of diseases that are uncommon in the receiving countries but may be so in the countries of origin;
- The collected information also shows that pregnant women, unaccompanied minors, victims of torture and people with mental post traumatic disorders pose special problems. Due to the factors mentioned above, mental health care uses to be poorly delivered.

## 2.5 Barriers to health access

Emergency humanitarian aid is usually provided by a combination of NGOs and mainstream health services. It is usually given free of charge: the crucial issue is usually whether it is available, not whether it is accessible. In normal situations, however, when health care is delivered by mainstream health services, provision is subject to rules of entitlement. Different groups (nationals, EU/EFTA migrants, third country nationals, beneficiaries of international protection, asylum seekers and undocumented migrants) are legally entitled to different levels of coverage. Therefore, unless these rules have been explicitly suspended, it is not enough for care to be available: migrants must also be entitled to receive it (see chapter 2.1). *Laws can thus provide a serious barrier* to accessing adequate health service provision. The resources may be available, but access to them by certain migrant groups may be limited (see chapter 2.4).

In addition, there are several kinds of *non-legal barriers* that can arise between service providers and their (potential) beneficiaries. The following can be distinguished:

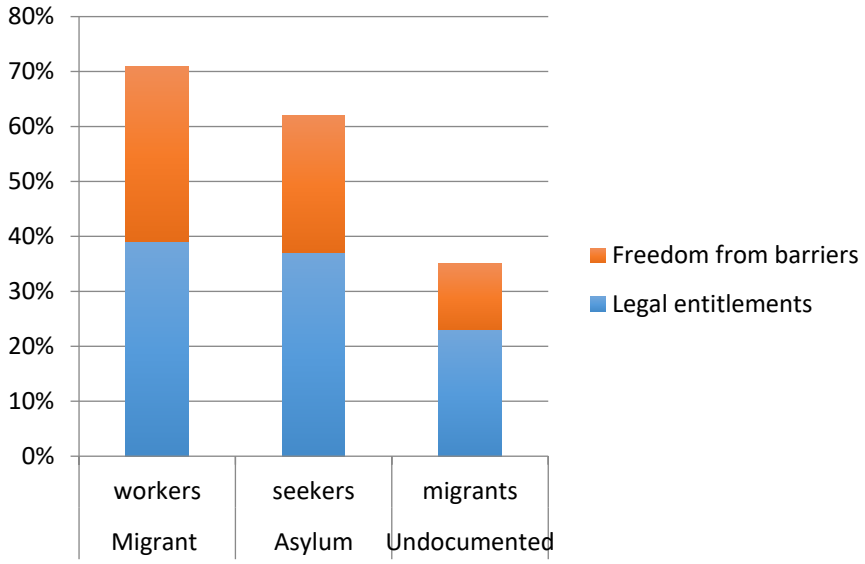
- administrative barriers (overcomplicated procedures, discretionary decisions);
- lack of information and/or of health literacy;

- barriers of language and culture; and
- – for undocumented migrants – the risk of being reported to the authorities.

At individual level, staff may simply be unwilling to help – though it should be remembered that many cases also occur of staff giving more help than a migrant is entitled to.

A lack of 'cultural competence' or 'sensitivity to diversity' in the actual delivery of care will also constitute a barrier. The MIPEX study has made a comprehensive overview of access to health services in European countries for three categories of migrants: migrant workers (regular), asylum seekers and undocumented migrants. Figure 3 shows how serious the problem of limited entitlement to care is.[4] A score of 100% indicates complete equity with national citizens, while 0% means that migrants are totally excluded from health care coverage. Even fully legal migrants enjoy only 72% entitlement, and this percentage decreases across the categories to 35% for undocumented migrants. As the level of legal entitlement goes down, so does the number of administrative barriers increase.

**Figure 3: Access to health care services for categories of migrants**




*Source:* MIPEX. http://www.mipex.eu/health

In addition to administrative barriers there are also the other types of barriers mentioned above, as well as the lack of responsiveness to migrants' special needs ('diversity sensitivity'), all of which further impede the delivery of good health care to migrants. For this reason, the accessibility of care should be regarded as at least as important (if not more) than its availability. Usually the services exist, but nearly all governments are reluctant to allow migrants to benefit fully from them. Often such policies are based on a mistaken belief that providing adequate health services to migrants will create an unstoppable flow of them into the country. However, evidence is lacking that health service provision is an important 'pull' factor compared to conditions of living and employment prospects.

[4] In measuring entitlements, account is also taken of the administrative barriers – difficult documentation and discretionary judgements – which may prevent a migrant from exercising a legal entitlement.

# 3 Need for coordinated and effective health response

In addition to more individual challenges related to the migrants' profiles, there are organisational challenges such as the availability, accessibility and quality of health services, caregivers' attitude and understanding of the law and bureaucratic barriers; as well as societal challenges such as the myriad of entitlements to health care and geopolitical negotiations on a common European approach to the refugee influx that severely impact the potential health response. Responding to these needs requires an enormous coordinated effort of EU Member State governments, Red Cross societies, (inter)national NGOs, the European Union, the UN agencies (especially UNHCR, WHO and UNICEF) and the International Organisation of Migration (IOM).

## 3.1 Existence of coordination mechanisms

Countries that have been traditionally destination countries for refugees, asylum seekers and other migrants often have an institutional response mechanism (e.g. Organization for the Reception of Asylum seekers in country X, State Agency for Refugees in Belgium; Office for the Protection of Refugees and Stateless in country Y; xxx). The twelve profiles completed show that at governmental level mainly Ministries of Health, Ministries of Interior or Public Health institutes are involved in the coordination of the health response.

Most countries with less experience with refugees or asylum seekers or new destination countries are currently in the process of creating the response mechanisms with high level meetings, e.g. Croatia and Greece.

## 3.2 Available resources for health response

The mapping exercise demonstrated that financial resources available for responding to the health needs of refugees, asylum seekers and other migrants are often not disclosed or that detailed is information unavailable.

Funding sources for recent arrivals, people in transit, asylum seekers come mostly from national governments, IOM, international and national NGOs (MSF, MdM, Red Cross…), and civil society organisations. Funding sources for people with refugee status granted and for undocumented migrants are usually provided by national governments, health insurance, and own contributions of the migrants.

## 3.3 Reasons for coordination of the health response

Analysis of these twelve profiles demonstrated that the health response of the EU Member States so far remains *fragmented*: the involvement of many different partners, not all acting in harmony, results in overlapping, duplication and unmet health needs because of the lack of adequate coordination, both within a Member State, at Member State and at European level.

Contextual elements to take into account are:

- The influx of refugees and asylum seekers is dynamic, influenced by changing politics, seasons and the evolution of major conflicts triggering it. New political agreements, such as the EU-Turkey statement of 18 March 2016 to address the migrant crisis and EU-Turkey cooperation, indicate the

need for preparedness to respond rapidly to a changing context. In addition, each European country presents its particularities in terms of culture, governance, and political situation that impact on the response offered.

- The EU Member States are dealing with a protracted crisis with increased impact on various local sectors, including health, aggravated by insufficient planning of a long-term integrated multi-sectoral response.
- The Member States' legal and policy frameworks do not always alleviate barriers ensuring access to health care. A gap exists between the recognition of the universal right of all to health care and its adherence in several EU Member States.
- Migration in itself is not a health risk but the migration process can often bring circumstances posing important health risks and challenges.
- The profile of the displaced population has become very gender and age diverse indicating an increased need for sexual, reproductive and child health services, as well as geriatric care.
- The health needs we are observing are demonstrating a compounded effect of acute critical health needs that warrant rather humanitarian interventions as well as health needs that require access to regular comprehensive health care and public health interventions provided by the countries' health systems:
- Many of these migrants are survivors of different types of violence. Some are victims of physical violence needing prostheses, there are victims of psychological trauma needing specialised treatment and there are others in need of specific clinical, psychosocial and forensic actions in response to sexual violence experiences. Sexual violence is also a specific reason for claiming asylum and a priority health concern, which requires both prevention and response interventions at all stages of migration and in all types of reception facilities.
- A number of migrants have serious chronic conditions (e.g. cancer, diabetes…) the treatment of which should be continued.
- Migrants' health goes beyond the traditional management of communicable diseases and is closely linked with the social determinants of health.
- Gaps exist in the national health information and disease surveillance systems. These, in turn, increase the risk of vaccine preventable diseases and outbreaks especially in the crowded conditions of reception or detention centres.
- Sometimes unnecessary mandatory health checks have been imposed in some Member States. The right balance needs to be found between ethics and people's' rights versus security pressures.

In conclusion, the above points emphasise the necessity of a highly flexible **coordinated response** anchoring migrants' health in a human rights framework and harnessing all partners, stakeholders and goodwill at national, local and municipal level. The absence of a coordination process may weaken the health system and its governance in the long run because of fragmentation of the health responses.

# 4 Further support from SH-CAPAC

SH-CAPAC stresses the importance of strengthening capacity in areas of **C**oordination practices, needs **A**ssessments, **P**lanning actions to strengthen the public health response, improving **A**ccess to health care, and strengthening health workers' **C**ompetencies for the delivery of migrant/refugee sensitive health services.

Different tools were developed for this purpose and can be found hereafter.

| **SH-CAPAC objective** | |
|---|---|
| **To support EU Member States under particular migratory pressure in their response to health related challenges** | |
| **SH-CAPAC tools** | |
| **Health coordination framework** for a coherent national and international response to meet the health needs of refugees, asylum seekers and other migrants | *See chapter/module X* |
| **Guide for the assessments** of health challenges posed by the massive refugee flow and of the health care response and public health interventions needed for the refugees, asylum seekers and other migrants' population | *See chapter/module X* |
| **Action plan framework** for implementing a public health response and strengthen a country's health system in order to address the needs posed by the refugees, asylum seekers and other migrants' influx | *See chapter/module X* |
| **Resource package** to reorient local strategies and plans for promoting and ensuring access of the refugees, asylum seekers and other migrants' populations to health care and public health interventions | *See chapter/module X* |
| Framework for a migrant-sensitive health care delivery model to be implemented in entry, transit and destination countries<br>**Training materials** for health workers | *See chapter/module X* |

Direct beneficiaries of the SH-CAPAC tools are national and regional health authorities of EU Member States, but also health professionals and administrative staff from GP practices, community health centres and hospitals, NGOs and Red Crescent facilities, who provide health services to the migrants.

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## Annex 2: Template of the country mapping profile

Co-funded by
the Health Programme
of the European Union

# National coordination of the health care response to refugees, asylum seekers and other migrants: *Working document*
# COUNTRY


***READER'S GUIDE:***

*The SH-CAPAC consortium is conducting a mapping of the European Union Member States' health response to the refugees, asylum seekers and other migrants entering, transiting or staying in their territories.*

*This working document summarizes the latest information on the influx of the different categories (see box 1 on Country Context) and on the coordination of the health care responses (see box 2) in [country]. It also maps the available information on the WHERE-WHAT-WHO of these health care responses (see box 3). This is done for different categories: (1) recent arrivals, (2) people in transit, (3) asylum seekers, (4) refugee status granted persons, (5) undocumented migrants, and where relevant, also for (6) unaccompanied minors. Lastly we would like to map the funding sources for which the Member State's input is appreciated (see box 4 on Funding of health care responses).*

*The information already completed below is based on different sources which were consulted online between January 20 and February 8 2016 and which is meant to give a first snapshot.* ***We would like to ask you to verify the information, to correct and amend where necessary and to complete where possible.*** *This mapping exercise will help the SH-CAPAC consortium to define a framework for effective health sector coordination for addressing the needs of the refugees, asylum seekers and other migrants in the European Union.* ***Please reply before February 16 2016 to ainhoa.ruiz.easp@juntadeandalucia.es with copy to birgit.kerstens@gmail.com and daniel.lopez.acuna.ext@juntadeandalucia.es.*** *More information on the SH-CAPAC project can be found in the leaflet in attachment and on www.easp.es/sh-capac.*

**Sources consulted:**

- xxx
- xxx

*Please provide us with any other sources that you deem appropriate for your country.*

<table>
<tr><th colspan="2">1. COUNTRY CONTEXT</th></tr>
<tr><td>When influx started<br>(by year up till 2015, month since 2015)</td><td>Up till beginning of 2015:<br>Since beginning of 2015:<br>(please complete or correct)</td></tr>
<tr><td>Current number as of Feb 1 (AS/ REF/ UDM/ unaccompanied minors)</td><td>A. Most recent data per category: ?<br><br>
<table>
<tr><th>Residing in [Country]</th><th>(month) 2015</th></tr>
<tr><td>Refugees</td><td></td></tr>
<tr><td>Asylum Seekers</td><td></td></tr>
<tr><td>Returned Refugees</td><td></td></tr>
<tr><td>Internally Displaced Persons (IDPs)</td><td></td></tr>
<tr><td>Returned IDPs</td><td></td></tr>
<tr><td>Stateless Persons</td><td></td></tr>
<tr><td>Various</td><td></td></tr>
<tr><td>Total Population of Concern</td><td></td></tr>
<tr><td>Originating from [Country]</td><td></td></tr>
<tr><td>Refugees</td><td></td></tr>
<tr><td>Asylum Seekers</td><td></td></tr>
<tr><td>Returned Refugees</td><td></td></tr>
<tr><td>Internally Displaced Persons (IDPs)</td><td></td></tr>
<tr><td>Returned IDPs</td><td></td></tr>
<tr><td>Various</td><td></td></tr>
<tr><td>Total Population of Concern</td><td></td></tr>
</table>
<br>B. Most recent data on total number: ?</td></tr>
<tr><td>Percentage of F/M/T, age groups and origin</td><td>A. Most recent data per category: ?<br><br>B. Most recent data by gender, age group, origin: ?</td></tr>
</table>

| **2. HEALTH CARE RESPONSES** | |
|---|---|
| *Please correct or complete the information where possible.* | |
| **Health care coordination at national/regional level** | A. **Existence of a national coordination mechanism of the health response**: YES/NO *(Please complete)*<br>B. **Explanation**: *(if yes, please describe how the mechanism works and who participates; if no, please describe why there is no coordination)* |
| **First entry assistance services** | |

**Response to 'An Agenda for Action' as agreed during the High Level Meeting on Refugee and Migrant Health in Rome in November 2015:**

*Cross the appropriate 'Yes', 'No' or 'There is no information available' option in the blue boxes. Additional information or sources can be mentioned underneath the box.*

| | | | |
|---|---|---|---|
| Integration of the health care services for refugees, asylum seekers end migrants into the existing national health systems | Yes | No | There is no information available |
| Limit initial screening upon arrival to relevant risk assessment | Yes | No | There is no information available |
| Non Communicable Diseases included in the provision of services | Yes | No | There is no information available |
| Active participation and empowerment of the refugees and migrants throughout all stages of health service provision, including design and planning | Yes | No | There is no information available |
| Training of health professionals involved in the provision of health care | Yes | No | There is no information available |

| **3. WHERE-WHAT-WHO** | | | |
|---|---|---|---|
| *Please correct or complete the information where possible.* | | | |
| **Migrant group** | **WHERE are they receiving the health care?** | **WHAT type of health care provision are they receiving?** | **WHO is the actor/agency providing the health care?** |
| (1) Recent arrivals | | | |
| (2) People in transit | | | |
| (3) Asylum seekers | | | |
| (4) Refugee status granted | | | |
| (5) Undocumented migrants | | | |
| (6) Unaccompanied minors | | | |

**4. FUNDING OF THE HEALTH CARE RESPONSES**

*Please provide us with any relevant information of funding made available by your country or other partners for health care responses:*

- *FUNDING SOURCES: where does the funding come from? e.g. Government, UN agency (UNHCR, IOM, WHO Euro,…), EU, NGO, civil society organisation, faith-based organisation, private organisation, international donor, (public/private) health insurance, other (please specify)*
- *FUNDING MECHANISM: how is the health care delivery being funded? e.g. envelope (for whole year/project), lump sum amount per asylum seeker/refugee, out-of-pocket expenses, third payer mechanism, emergency/contingency budget.*
- *FUNDING AMOUNT: Give the amount spent on health care responses, in Euros, per year/month; if available also provide the pledged amount.*
- *COMMENTS.*

| **Migrant group** | **Funding source** | **Funding mechanism** | **Funding amount** | **Comments** |
|---|---|---|---|---|
| **(1) Recent arrivals** | | | | |
| **(2) People in transit** | | | | |
| **(3) Asylum seekers** | | | | |
| **(4) Refugee status granted** | | | | |
| **(5) Undocumented migrants** | | | | |

# Annex 3

# Mission report to Bulgaria

Co-funded by
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**SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC**

# MISSION REPORT TO BULGARIA

## 29 June to July 2, 2016

SH-CAPAC Participants: Daniel López-Acuña and Jacqueline Gernay









This report is part of the project '717275 / SH-CAPAC' which has received funding from the European Union's Health Programme (2014-2020). The content of this report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

## ○ **Day 1: 29 June**: Sofia:

*Meeting with Dr. Angel Kunchev, Chief State Health Inspector*

- Discussion and agreement on work agenda for the next 2 days.
- Presentation of the latest refugee situation and main organizations involved of which the most important are the State Agency for Refugees (SAR) and the Bulgarian Council on refugees and migrants. SAR falls under the Ministry of Interior (MOI) .It covers costs incurred by the majority of the detention centres. The Bulgarian Council on refugees and migrants is in close collaboration with the presidency as well as with UNHCR.
- The MOI forwards weekly information to the MOH in terms of general statistics per centre by age, gender, and country of origin.
- Each detention centre has a medical facility offering basic services free of charge (bills sent to SAR).
- At June 2016: 6632 refugees had been registered mainly from Afghanistan, Syria and Iraq.
- The Centres depending from SAR have a capacity of 5130 but with an Occupancy Rate (OR) of 19%. The MOI centres have a capacity of 940 with an OR of 62%. As such there were about 1500 refugees in the centres in June 2016. They are mainly young males (a change compared to last year).
- The country is essentially a transit country with refugees staying in general a few days with very few not extending their stay beyond weeks.
- Turkey is not respecting the EU agreement (is not taking back refugees).

## ○ **Day 2: 30 June** 2016: Sofia

a. *Meeting with national stakeholders.*

Present were: Dr Angel Kunchev, Chief State health Inspector, Director Epidemiology, Director Communicable Diseases MOH, Sofia Regional Health Inspectorate (RHI) of Sofia, Bulgarian Red Cross, WHO, State Agency for Refugees (SAR), Bulgarian Council on Refugees and Migrants, IOM, National Security.

Thee presentation were made by the SH-CAPAC team.

a) A summary of the situation in Europe and of the project by Daniel López Acuña,

b) The coordination Framework (WP1) by Jackie Gernay.

c) The salient aspects of WP2,3, 4 and 5 by Daniel López Acuña.

Q&A and discussion with participants:

**Main points**:

i. The Bulgarian Red Cross is very dynamic and responsive to the humanitarian component of the crisis. There are very few NGOs active in the field. They have very good collaboration with the MOH and the centres. They provide weekly information to SAR and UNHCR (not MOH except for TB cases) and hold monthly meetings with various stakeholders re health, hygiene and other needs in the centres. They are the implementing arm of UNHCR.

ii. There is a gap in health information integration in general, (except for communicable diseases) and as it relates to refugees. There is a necessity for consolidation of the health information through a common repository of information (as the humanitarian health cluster does) and to reach consensus on a few essential variables to report on.
iii. WHO made the link with SDGs and the fight against inequity and related work done by the United Nations Country team (UNCT). Migrant health does not appear in their WHO-Bulgaria Biennial Country Agreement as such but is integrated in other programmes such as MCH and NCD. They support a project of 180 health mediators who work mainly in Roma communities and suggested their use with refugees. However, there are about 1 million Roma, representing approximately 10% of the total population. They are a very vulnerable population subject to inequities. They are not covered by the national health insurance. The migrant population in comparison is very small and transitory. But they highlight the inequities of ethic minorities within the country. Hence separate health services for migrants does not make any sense but reinforces the need for an integrated health system for all.
iv. The Red Cross has a Social mediators initiative. They are migrants trained to act as mediators in the various centres. It was suggested to bring the health mediators and social mediators initiatives together in order to share the training between both groups. Red Cross has offered to train the 180 health mediators.
v. There is need for coordinated planning including a contingency component. A simulation exercise (similar to other WHO emergency simulation exercises) was suggested and welcomed by the participants.
vi. The Bulgarian council for refugees is organizing an Advocacy workshop with UNHCR. In August. The possibility of support by SH CAPAC, especially through the Resource package developed as part of the Work Package 4 was offered and welcomed. SH-CAPAC will follow with Angel Kunchev on this possibility of an ulterior mission.
vii. Interest was expressed on having Bulgarian participants from MoH, Red Cross and Ministry of the Interior joining the on line pilot training course that will be offered by SH-CAPAC during the fall.
viii. There is opportunity and receptivity to have a monthly meeting to convene all stakeholders especially. However, the adequate leadership to do it should needs to be identified. It could be done jointly by the Ministry of Health and the State Agency for Refugees – SAR.

b. *Visit to the oldest SAR refugee centre in Sofia (only interview with staff, no visit of premises allowed*)
i. 1 nurse 1 Dr (14 years in job).
ii. They see refugees sent by the migration authorities. They come from Syria, Afghanistan and Iraq. The nurse speaks Arabic.
iii. They cover basic pathologies but need to refer to GPs for any investigation, specialist referral etc. The GP is the gatekeeper. The system is not at all efficient as the alternative is to send the patient to the emergency department

of the hospital. GPs do not speak the refugees' language and some are reluctant, as they have to claim reimbursement from SAR.

iv. There are no agreements with any local hospital.
v. The refugees are mainly young males, in good health but frequently have skin conditions (scabies).
vi. Genetic pathologies such as thalassemia and sickle cell anaemia are seen.
vii. They see unaccompanied minors (one 8 years old had left Afghanistan at age 5 and had passed borders several times from Greece and Turkey acting as a leader for the group). He disappeared from centre and there is no system in place to remedy to this issue (prevention or search).
viii. Migrants are free to leave the centre at any time and do not stay more than a few days.

- **Day 3: July 1**: visit to the region of Haskovo (Southern Bulgaria near the border with Turkey)

*1. Visit to the Regional Health Inspectorate (RHI)*

Present were: RHI director, directors epidemiology, communicable diseases, security, information, deputy director of the regional hospital, Bulgarian red cross, representatives of 2 centres ( Liyubimets and Postrogor), IKAR (NGO dealing with TB funded by global fund), various social workers from NGOs working in the centres.

The session was supported by an interpreter and this slowed down the dialogue process.

There were two presentations. The first presentation of the SH-CAPAC project by Daniel López Acuña and a presentation on the coordination framework by Jackeline Gernay.

Discussion and recommendations:

I. Centres have good coordination with hospitals and RHI. GPs are not needed as gatekeepers. Referrals are easy. Health workers from the RHI express frustration at patients leaving before results come back. Patients sign their discharge even when very sick.
II. Medical information is given to migrants but is destroyed by them as they do not wish to be recognized as having been registered in Bulgaria (Dublin agreement).
III. When asked about a "what if "contingency situation: participants say they have sufficient infrastructure and would be able to cope. When asked if Bulgaria was to receive a quota of 10,000 asylum seekers, they reacted by saying it would not be a problem, as migrants would leave anyway to go north through the Serbian border.
IV. NGO members (mainly social workers) working directly at the centres complain of poor recognition of their work and of not being in the loop.
V. Training needs identified: i) address protection of health workers, ii) address gender issues (separation of women); iii lice treatment.
VI. Local Red cross is active and interested.
VII. There is opportunity to have a monthly meeting to integrate all stakeholders especially NGOs. However, the adequate leadership to convene a local coordination group needs to be identified.

*2. Visit to the centre of Postrogor*

i. The centre is an old army camp. Refugees are still housed in the old buildings but new facilities have been built with the support of the EU DG Home on a large campus. This includes family units with bathroom, kitchenette and AC to house about 400 persons as well as a new registration centre and medical centre.
ii. Two medical assistants were interviewed.
iii. They have Arabic interpreters as only Syrian and Iraqi migrants are housed there. The region opted to house the Afghan refugees in another location to simplify translation needs.
iv. They cover basic medical services, check for faecal parasites and malaria and offer HIV testing. (All done with consent form in Arabic).
v. The system is organized. There is no need for GPs as gatekeepers. An agreement with the local hospital has made referrals easy. They also refer women to female doctors but female gynaecologists are not always available in the country).
vi. Staff appear motivated and organized (registers well kept and up to date).
vii. Main pathologies encountered: Gastroenteritis, Respiratory Tract infections, Scabies and Leishmaniosis. They have seen war injuries (gunshot wounds) but early in the crisis.
viii. Staff encountered several cases who signed discharges for themselves or dependents (including 2 kids in winter with severe frost bites to lower extremities requiring hospitalization).
ix. They see a mix of families and refugees of both sexes and different age groups.
x. The average length of stay is 72 hours so there is very little opportunity to discuss violence especially gender based violence or to address mental health needs. Staff act on suspicion and refer to female social worker.
xi. Refugees are free to leave the campus but gate is closed at 10pm for security reasons.

**Main conclusions and recommendations**

For Bulgaria

1. Share with the SH-CAPAC project the program of the advocacy workshop that will be organized by the Bulgarian Council on Refugees in collaboration with UNHCR in August-September .Request if so desired the support from the SH-CAPAC project though a technical support mission.

2. Establish a standing national coordination mechanism for the health response to refugees, engaging all involved stakeholders, governmental and non-governmental. This could be convened by the Ministry of health and the Bulgarian council of Refugees, meet bimonthly and start consolidating the health information gathered by the different stakeholders for producing a periodic comprehensive situation report.

3. Establish a standing local coordination mechanism for the health response to refugees, engaging all involved stakeholders, governmental and non-governmental in the Haskovo Region. This could be convened by the Regional Health Inspectorate, meet bimonthly and start consolidating the health information gathered by the different stakeholders for producing a periodic comprehensive situation report.

4. Participate with two people, possibly from MoH and Bulgarian red Cross, in the SH-CAPAC Granada workshop of training of trainers, and adaptation of the training strategy to local and national situations, which will take place on September 15th and 16th.

5. Propose the names of three people for Bulgaria for participation in the SH-CAPAC on line training course, preferably from Ministry of Health, Ministry of Interior and Bulgarian Red Cross.

For the SH CAPAC project:

1. Support the advocacy workshop organized by the Bulgarian Council on Refugees in August-September, mainly through colleagues associated to the elaboration of the Resource package for Improving Access pertaining to Work Package 4.

2. Include a component on the need for consolidated information and periodic situation reports as part of the coordination framework (similar to the health cluster).To be done by the EASP and University of Ghent as part of the WP1 (Jackie, Ines, Birgit).

3. Include a component on scenario building and projections of health needs and demands as part of the guide for assessing health needs and health protection resources of WP2.To be done by the EASP and University of Copenhagen as part of the WP2 (Iain, Mette and Allan).

4. Incorporate elements of contingency planning including a simulation exercise as part of the framework and guidance of WP3 (formulation of action plans) The WHO and OCHA guidelines and experiences on this may be very helpful (to be done by Alberto, Daniela and Eva).

5. Ensure that the training materials developed as part of WP5 include gender sensitization and protection of health workers (this last one is to be added to the contents of the training course).This should be done by University of Ghent and EASP (Lotte, Ainhoa and Olga).

6. Ensure the participation of at least two people from Bulgaria to the Granada workshop of training of trainers, preferably Angel Kunchev from the Ministry of Health and Maria Stanovaya from the Bulgarian Red Cross (to be followed by Olga, Ainhoa, Natxo and Daniel).

7. Secure at least three slots for Bulgaria in the SH-CAPAC on line training course, preferably from Ministry of Health, Ministry of Interior and Bulgarian Red Cross (Daniel, Natxo, Olga and Ainhoa to follow).

# Annex 4

# Guide for assessment of health needs and available health protection resources (draft)

Co-funded by
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**SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC**

# GUIDE FOR ASSESSMENT OF HEALTH NEEDS AND AVAILABLE HEALTH PROTECTION RESOURCES

Final Draft, June 2016




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## Users guide

- The present document aims at supporting individual European countries in assessing: 1) the health needs of the refugees, asylum seekers and other migrants who are part of the recent influx to European countries, and 2) the available health protection resources in the given European country. The objective of the assessment is to identify gaps between health needs and available resources to provide the basis for planning and carrying out action in terms of necessary health provision and preventive measures for refugees, asylum seekers and other migrants. Guidelines to support the process of action planning and strategy development are provided separately in The SH-CAPAC WP3 report 'Planning for Action'.

- This guide for assessment speaks to the national or subnational health authorities responsible for coordinating and developing response and contingency planning of meeting the needs of the migrant populations in question. The health assessment will be an integrated part of the process of planning and strategy development (see WP3). The guide is also intended for the different governmental and non-governmental actors as well as international and civil-society organization who participate in the national and local efforts at responding to the health needs of refuges, asylum seekers and other migrants.

- Flexibility in the application of this guide for assessment is highly recommended. This guide for assessment and the tools provided in the guide are not the only solutions for assessment processes.

- This guide currently has the shape of work-in-progress. Together with the WP3 report (Framework for the development of action plans for implementing a public health response and to strengthen a country's health system in order to address the needs posed by the influx of refugees, asylum seekers and other migrants) the guide will be presented and discussed at the SH-CAPAC workshop on 17 and 18 May 2016 in Copenhagen, Denmark. Revisions will be made publicly available on http://www.easp.es/sh-capac/.

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## List of figures



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## List of acronyms

| | |
|---|---|
| AT | Assessment team |
| BEOC | Basic emergency obstetric care |
| CS | Civil society |
| CD | Communicable disease |
| CEOC | Comprehensive emergency obstetric care |
| CESCR | UN Committee on Economic, Social and Cultural Rights |
| ECDC | European Centre for Disease Prevention and Control |
| ECHO | European Community Humanitarian Aid Office |
| EPI | Expanded Programme of Immunization |
| EU | European Union |
| FGM | Female genital mutilation |
| GAHNR | Guide for assessment of health needs and available health protection resources |
| GP | General practitioner |
| HCT | Health coordination team |
| HIV | Human immunodeficiency virus |
| HRH | Human resources for health |
| IASC | Inter-Agency Standing Committee |
| ICCPR | International Covenant on Civil and Political Rights |
| ICESR | International Covenant on Economic, Social and Cultural Rights |
| IEC | Information education communication |
| IFRCRC | International Federation of Red Cross and Red Crescent Societies |
| IOM | International Organization for Migration |
| LGBTI | Lesbian, gay, bisexual, transgender/transsexual and intersexed |
| LHA | Local health authority |
| M/C | Maternal/child |
| MdM | Médecins du Monde (Doctors of the World) |
| MI | Ministry of Interior |
| MISP | Minimum Initial Service Package |
| MOH | Ministry of Health |

| | |
|---|---|
| MS | Member State |
| MSF | Médecins sans Frontières (Doctors without Borders) |
| NAT | National assessment team |
| NCD | Non-communicable disease |
| NGO | Non-governmental organization |
| NHA | National health authority |
| PHC | Primary health care |
| PMTCT | Prevention of mother to child transmission |
| PTSD | Post-Traumatic Stress Disorder |
| RH | Reproductive health |
| RHA | Regional health authority |
| SGBV | Sexual and gender-based violence |
| SHC | Secondary health care |
| SRH | Sexual and reproductive health |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| THC | Tertiary health care |
| UCPM | (European) Union Civil Protection Mechanism |
| UDHR | Universal Declaration of Human Rights |
| UN | United Nations |
| UNCT | United Nations Country Team |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations International Children's Emergency Fund |
| WASH | Water, sanitation and hygiene |
| WHO | World Health Organization |
| WP | Work package |

## Glossary

- **Health needs**: refer to needs related to health and wellbeing; for example, needs for medicine, needs for nutrition, needs to be safe from physical and psychological harm, needs for specific health care and health prevention.
- **Health protection resources**: refer to both health care and prevention and include health and social services
- **Assessment team**: is the team appointed by the Health coordination team to do the assessment. Several national/local assessment teams can be appointed in the national context to carry out the assessment in coordination.
- **Health coordination team**: is the core/executive team designated by the leading governmental authority/agency in providing health care to migrants (from asylum seekers to undocumented migrants) to lead the coordination of the health response to the influx of migrants.
- **Country scenario:** characterises the migration situation of a country. Scenario A refers to the situation of migrants arriving/being in transit, while scenario B refers to the situation of migrants waiting to settle (asylum seekers) and/or in the process of settling (granted protected status). Various health protection resources may be of specific importance in different scenarios.
- **Migratory stage**: refers to a stage or period during the trajectory of flight/migration. The asylum seeking process is for example a specific stage of migration that is followed by the grant or rejection of protected status in a given country. Health needs and risk may shift, change and/or accumulate during different migratory stages.

# INTRODUCTION

## 1 Why do we need a health needs assessment?

A health needs assessment is a systematic process of collection and analysis of information regarding the type, depth and scope of a problem. Accordingly, the health needs assessment is an essential instrument to develop a respond to needs in sudden, acute humanitarian crises, but also crucial for addressing long-standing and well-known deficiencies.

A needs assessment uses various methods to collect and analyse information, including collection and systematization of existing knowledge and information as well as collection of new data through interviews, field visits or surveys. The collected information enables the organisation (governmental or non-governmental) to prioritize, plan and coordinate response and future intervention (see SH-CAPAC WP3 report on Development of Actions Plans).

Health needs assessment is a necessary and integrated part of establishing and/or strengthening national health coordination in the health response and contingency planning during the current influx of refugees, asylum seekers and other migrants to European countries (see SH-CAPAC WP1 report on Health Coordination Framework).

### 1.1 Purpose of Guide for Assessments of Health Needs and Available Health Protection Resources

This Guide for Assessment of Health Needs and Available Health Protection Resources (GAHNR) is developed to assist European countries in these efforts of health response.

The GAHNR aims at providing assistance in gathering a given country's reservoirs of knowledge and information among health professionals (primary and specialized care), health managers, national and local NGOs, civil society and the target population. A primary goal of the needs assessment is to collect, systematize and ensure sharing and dissemination of this reservoir of knowledge in order to (i) create an overview of the current situation/conditions in terms of health needs and available/accessible health protections resources, and to (ii) establish a foundation to develop a preparedness plan for potential scenarios of the influx of refugees (i.e. contingency planning in terms of reflections on strengthening and sustaining existing resources and developing needed extra resources).

The GAHNR directs attention towards two primary foci:

1) **Identifying health needs and risks, and**
2) **Mapping and/or assessing health protection resources**

The aim of the assessment is to identify gaps between 1) and 2), to provide the basis for planning (see SH-CAPAC WP3) and carrying out action in terms of necessary health provision and preventive measures for refugees, asylum seekers and other migrants (see SH-CAPAC WP4 and WP5).

Hence, the assessment guide contributes to the overall objective of the SH-CAPAC project: to ensure available, accessible and appropriate health protection resources for refugees, asylum seekers and other migrants (including a specific focus on vulnerable groups such as unaccompanied minors and pregnant women.

### 1.2 Current situation of influx of refugees, asylum seekers and other migrants to Europe

Meeting the extensive and diverse health needs of the massive influx of refugees and other migrants to European countries poses different challenges in different countries. This complexity must be considered not

only in the health response but also in the complete process of health needs assessments. In other words, the assessment must be contextualised by taking into account various intersecting factors; including country scenarios based migratory stages (first arrival/transit/settling), different migrant groups (e.g. unaccompanied minors) and specific areas of health in need of attention (e.g. SRH, mental health, socio-environmental health).[1]

### 1.2.1 Country scenarios and migratory stages

Two main scenarios regarding the challenges of the migrant influx to European countries are identifiable: Scenario A of first arrival/transit, and Scenario B of settlement (/destination).

**Scenario A: Arrival and transit**
Migrants arrive in large numbers in particular locations, and may stay for relatively short periods of time, days or even hours. The numbers frequently overcome the capacity of existing health and other services to receive them. Many arriving migrants have survived an arduous journey involving smuggling, exploitation, crossing deserts, mountains, seas. In countries of first arrival/transit many challenges faced are often of humanitarian, acute character.

**Scenario B: Settlement (asylum seeking + settling with protected status)**
Migrants arrive mainly to seek asylum. The total numbers of migrants might be relatively big, but the influx is continual and distributed over a relatively long lasting time period of weeks or months.

The health problems and needs of the settling migrants are generally the same as those of European populations. The main differences are those needs which are connected with and a consequence of their refugee and/or migrant experiences. The violence and threats of violence from which they have escaped followed by the many traumatic experiences on the journey, including sexual and gender-based violence have resulted in a high prevalence of mental health problems among this population. Many important problems experienced in providing health care for migrants have to do with the complex administrative and legislative arrangements for accessing care and a variety of challenges to providing quality care by professionals.

The settlement scenario covers a range of migratory stages. When doing a health needs assessment particularly two stages must be addressed separately: 1) the asylum seeking process, where asylum seekers are waiting in specific accommodation facilities, and 2) the settling process when protected status has been granted and they, as refugees, must integrate into the national health system.[2]

Table 1.1 below gives an overview of essential elements and aspects to assess and how the assessment process may be approached according to scenario A (arrival/transit stage of migration) and scenario B (asylum seeking/settling stage of migration). While there are many common challenges to be addressed in the two

[1] See SH-CAPAC report X (the 'umbrella doc' in prep.)

[2] The mentioned migratory phases in need of attention are highlighted because different phases of a migration trajectory underlie various health needs and problems and available health protection resources. Access to health in terms of entitlements to health care services are for example determined by the status of the migrant as arriving or 'in transit', waiting to apply for asylum, asylum seeking or granted protected status.

scenarios, there are specific issues that require different approaches. In scenario A a specific objective of the needs assessment is to gather information that can facilitate action to meet the health need of a large number of migrants when local capacities and resources may be specifically challenged. The health needs and risk factors often require humanitarian crisis response (and contingency planning) based on corporation between governments and international organisation with crisis management expertise and resources. The assessment may in this case emphasise mapping available resources (e.g. medicine and human resources) and ensuring safe accommodation.

In scenario B a specific objective of the needs assessment is to develop informed decision making enabling organisation of health response to a large number of people waiting for asylum or having achieved protected status and therefore being in the process of integration into national health systems and society. While focus in asylum centres may also be on resources available and ensuring safe accommodation, awareness is pertinent to the effectiveness/access to general health protection services. Moreover, due to longer term perspectives of the health response, emphasis will in this scenario to a higher degree (and more in-depth) be on mental health issues and more general health prevention.

**Table 1.1 The assessment approach according to scenario A and B**

| | **Scenario A** | **Scenario B** | |
|---|---|---|---|
| **Migration stage** | **First arrival/transit** | **Asylum seeking process** | **Settling (transition phase)** |
| **Level of assessment** | National/regional/local | National/regional/local | Regional/Local |
| **Assessment Dimension** | | | |
| **Socio-demographic mapping** (see Chapter 3/Toolkit I) | Socio-demographic overview | Socio-demographic overview (extended) | Socio-demographic overview (extended) |
| **Needs and risks identification** (see Chapter 4/Toolkit II) | Qualitative needs and risk identification inquiry | Qualitative needs and risk identification inquiry | Qualitative needs and risk identification inquiry |
| **Health services mapping and assessment** (see Chapter 5/Toolkit III) | Quantitative mapping: availability of primary and secondary health care services and resources<br><br>Qualitative mapping: identifying effectiveness/access/entitlements | Quantitative mapping: availability of primary and secondary health care services and resources<br><br>Qualitative mapping: identifying effectiveness/access/entitlements | Qualitative mapping: identifying effectiveness/access/entitlements |
| **Accommodation facility assessment** (see Chapter 6/Toolkit IV) | Assessment of general health, safety and security (incl. SGBV protection) in accommodation facilities | Assessment of general health, safety and security (incl. SGBV protection) in accommodation facilities | |

*Attention*: Although one scenario may be predominant in a specific country setting, it is important to notice that all countries are shaped by dynamics of both scenarios A and B. In particular countries, that were earlier mainly arrival and/or transit countries but now increasingly face challenges as destination/settling countries.

### 1.2.2 Vulnerable groups

The large numbers of people arriving in and migrating though Europe have different backgrounds, are in different physical, mental and social conditions, and positioned differently in terms of (e.g.) gender, age, educational level and socioeconomic status. The health problems they experience and health risks they are exposed to will differ in kind and degree, calling for an intersectional[3] rather than a generalising approach to

[3] Intersectionality recognizes that individuals and groups are shaped by multiple and intersecting identities. These identities often inform an individual's world view, perspective and relationship to others in society. An Intersectional perspective or framework encourages policymakers and social change leaders to identify the ways in which race, class, gender, ethnicity,

analysing to the problems in each scenario and migratory stage. This means that awareness is important to vulnerable groups, such as:

- Unaccompanied minors
- Children and adolescents
- Pregnant women
- People with disabilities
- Elderly
- Undocumented migrants

It also implies necessary awareness to the ways different factors intersect, potentially positioning a person in an increased vulnerable position; for example, being unaccompanied minor *and* pregnant *and* in a transition stage of migration.

### 1.2.3 Health areas

The various scenarios and stages of migration potentially increase health risk in different ways and degrees. Different vulnerable groups also may face different health challenges during their trajectory of migration. Awareness to these different health areas and how these health areas intersect with the migration trajectory is crucial in the both assessment of health needs and resources and when coordinating and planning targeted action. Table 1.2 below gives a list of health areas that must be kept in awareness when assessing (and further planning and responding to) the needs of refuges, asylum seekers and other migrants. Table 1.1 gives headlines, whereas information on risk factors within different scenarios (arrival/transit/settlement) can be found in annex 1. Annex 1 also includes list of references to secondary sources of information and assessment within each area of health.

| **Table 1.2 List of essential areas of health needs (*Risk factors by country scenario in annex 1)*** |
|---|
| **SEXUAL AND REPRODUCTIVE HEALTH** |
| STD/HIV TRANSMISSION AND CARE |
| SRH OF MINORS |
| **SEXUAL AND GENDER BASED VIOLENCE** |
| PREVENTION |
| HOLISTIC CARE FOR VICTIMS OF SGBV |
| **MATERNAL AND CHILD HEALTH** |
| ANTENATAL, INTRAPARTUM AND POSTPARTUM CARE |
| NEWBORN AND CHILD HEALTH |
| FAMILY PLANNING AND CONTRACEPTION |
| **MENTAL HEALTH** |
| DEPRESSION |
| SUICIDAL BEHAVIOUR |
| POSTTRAUMATIC STRESS REACTIONS |
| PTSD |
| AGGRESSION OR TEMPER TANTRUMS (SHOUTING, CRYING, AND THROWING OR BREAKING THINGS); NERVOUSNESS, HYPERACTIVITY AND TENSION; SPEECH PROBLEMS OR MUTISM |
| SUBSTANCE USE DISORDERS |
| PROLONGED GRIEF DISORDER |
| PERPETRATION OF PERPETRATION OF DOMESTIC AND SEXUAL VIOLENCE |
| OTHER MENTAL DISORDERS |

sexual orientation, ability and status influence public policy outcomes at the national, state and local levels. This approach can also inform advocacy efforts aimed at increasing equity and equality in society. Mason CN. Leading at the Intersections: An Introduction to the Intersectional Approach Model for Policy & Social Change. New York: Women of Color Policy Network, New York University Robert F. Wagner, s.a. http://www.racialequitytools.org/resourcefiles/Intersectionality%20primer%20-%20Women%20of%20Color%20Policy%20Network.pdf (retrieved: March 31st, 2016).

| **NON-COMMUNICABLE AND CHRONIC DISEASES** |
|---|
| CARDIOVASCULAR DISEASES |
| ARTHRITIS |
| CHRONIC RESPIRATORY DISEASES |
| DIABETES |
| **INJURIES** |
| TORTURE |
| SELF-INFLICTED INJURIES |
| OTHER INJURIES |
| **COMMUNICABLE DISEASES AND VACCINATIONS** |
| TUBERCULOSIS |
| MALARIA |
| LOUSE-BORNE RELAPSING FEVER (LBRF) |
| TYPHOID FEVER, SCABIES, AND CHOLERA |
| UNDERVACCINATION |
| INFLUENZA |
| **SOCIO-ENVIRONMENTAL HEALTH** |
| ENVIRONMENT |
| PSYCHO-SOCIAL |

## 1.3 A three phase assessment process: Planning, data collection and report

The GAHNR works as an independent guideline. However, the Guide is developed as an integrated part of SH-CAPAC project (see background report x) and the health needs assessment is part of a cohesive effort to support health coordination, carrying out assessments, planning, ensuring access to health care and capacity building in European countries under particular migratory pressure.

The assessment process, as a separate element within this cohesive effort, is in this guide presented in three phases: Phases A, B and C. Figure 1 illustrates theses phases, while table 1.3 below gives an overview of activities within each phase and all tools provided in the GAHNR. In Phase B, comprising data collection, the tools are presented as part of Toolkits within the different assessment dimensions. Please notice that the activities and tools are suggestions and not the only solutions for assessment processes.

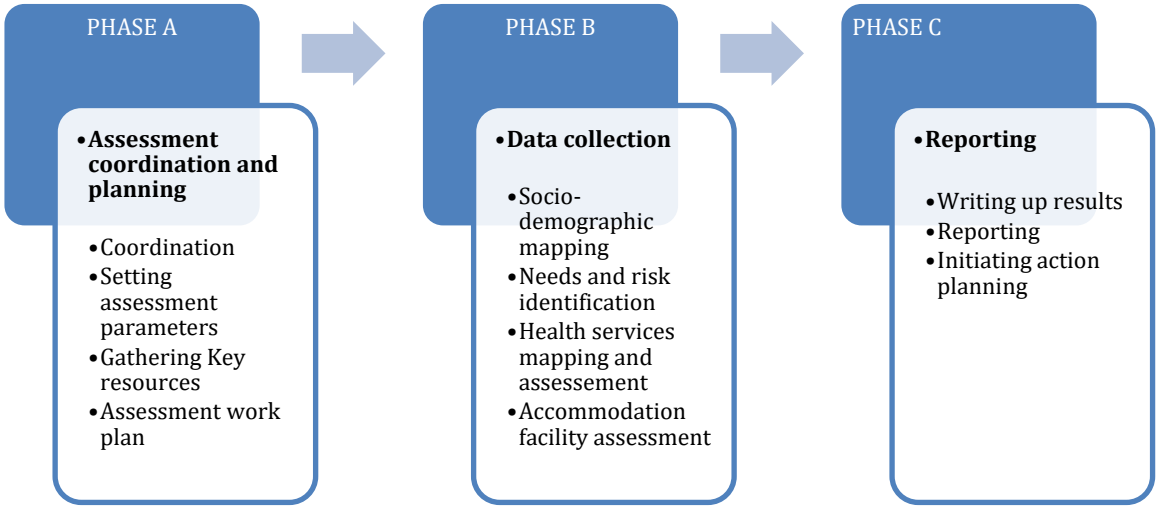


**Figure 1: Assessment Phases**

| Table 1.3 Activities and list of tools within assessment phases | | |
|---|---|---|
| **Phases** | **Activity** | **Tools provided** |
| **PHASE A: Assessment coordination and planning** | Appointing assessment team(s) | *See also guidelines of SH-CAPAC WP1* |
| | Setting parameters and contextualising the assessment | **Tool A1** Assessment Parameters Checklist |
| | Identifying and gathering key resources and stakeholders | **Tool A2** Stakeholder Checklist |
| | Making an assessment plan | **Tool A3** Sample work plan |
| **PHASE B: Data collection** | **DIMENSION I**: Socio-demographic overview | **TOOLKIT I**<br>**Tool 1.1** Socio-demographic mapping<br>**Tool 1.2** Resources: Stakeholders and information sources |
| | **DIMENSION II**: Needs and risk identification | **TOOLKIT II**<br>**Tool 2.1** Key information guide to assess contextual health needs and risk factors<br>**Tool 2.2** Key Question Guide on health needs and health risks |
| | **DIMENSION III**: Health services mapping and assessment | **TOOLKIT III**<br>**Tool 3.1** Assessing interpretations of migrant entitlements to care<br>**Tool 3.2** Mapping primary health care facilities<br>**Tool 3.3** Assessing availability of primary health care services<br>**Tool 3.4** Assessing availability of secondary health care services<br>**Tool 3.5** Assessing access to health care services |
| | **DIMENSION IV**: Accommodation facility assessment | **TOOLKIT IV**<br>**Tool 4.1** Assessing general health protection at accommodation centres<br>**Tool 4.2** Assessing SGBV protection at the accommodation facilities |
| **PHASE C: Reporting** | Writing up assessment notes<br>Reporting and sharing results | **Tool C1**: Sample summary framework |
| | Initiating action planning | *See guidelines/tools of SH-CAPAC WP3* |

# PHASE A: Assessment Planning

# 2 COORDINATION AND PLANNING

A basic precondition to carry out the assessment of health needs and available health protection resources is the establishment of a coordinating mechanism bringing together participating (sub)national and international stakeholders involved in the health response to the recent influx of refugees, asylum seekers and other migrants; for example, a (sub)nationally appointed Health Coordination Team (HCT) (see WP1 report on Health Coordination Framework).

As described in the Health Coordination Framework, it is necessary to ensure that local health authorities in the affected locations are involved in an intersectoral coordination body, and that a local Health Coordination Mechanism is formed, representing all the relevant state, NGO and voluntary agencies (see chapter 2 in the health coordination framework).

The coordination and planning phase of the assessment includes four elements: appointing the assessment team(s), setting parameters of a contextualised assessment, identifying main agents and keys resources and deciding on sampling methods.

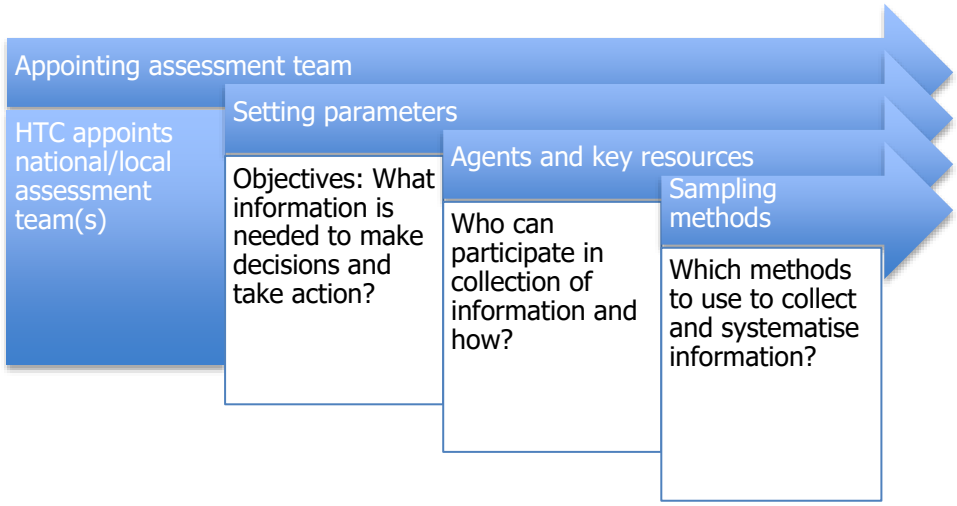


**Figure 2: Planning assessment**

## 2.1 Appointing an assessment team

An assessment team is appointed by a Health Coordination team (see WP1). This team carries out the assessment and reports back to the Health Coordination team to initiate a process of planning and strategy development (see WP3).

Since the assessment consists of different tools and elements it can be effective to assign different tasks (e.g. socio-demographic overview, contextual needs and resource identification and resource inventory and mapping) to different teams based on their specific skills and access to information. If more teams are appointed, the HCT ensures coordination of collaboration and shared information between these teams or one assessment team has a coordinating role.

## 2.2 Setting parameters and contextualising the assessment

When initiating the assessment, careful planning and engagement with key stakeholders helps to ensure that all critical dimensions are taken into consideration; that the assessment builds on and uses all existing knowledge and available information resources; and that required resources are provided.
The first step of the assessment planning is to review the plans of the HCT and any other previous plans of assessment and strategy development in the given context. Any previously carried out assessment or assessment strategy in country (or neighbouring countries facing similar challenges) can provide important information to identify the parameters of (and facilitate) the assessment.[4]

During this review process the AT must consider and identify what information is needed to take action; including reflections on:

- At which level(s) to do the assessment (national/regional/local)
- Which scenarios and stages of migration to emphasise in the assessment
- Which dimensions to include in the assessment (socio-demographic overview, needs and risk identification, resource mapping, accommodation facility assessment, others)
- How to allow focus on different health areas and ensure sensitivity to vulnerable groups

Tool A1 can be used when setting the parameters of the health needs and resource assessment to ensure explicit considerations of the potential elements and dimensions of the assessment.

| **TOOL A1: Assessment Parameters Checklist** | | | | |
|---|---|---|---|---|
| **Question** | **Yes** | **No** | **Maybe** | **Why or why not?** |
| Will the assessment take into account the following stages of migration? | | | | |
| Scenario A: arrival/transit | | | | |
| Scenario B: asylum seeking process | | | | |
| Scenario B: settling | | | | |
| Other? | | | | |
| Will the assessment be carried out on following levels? | | | | |
| National level | | | | |
| Regional level | | | | |
| Local (municipal/city) level | | | | |
| Other? | | | | |
| Will the assessment take into account the following assessment dimensions? | | | | |
| 1: Socio-demographic overview | | | | |
| 2: Needs and risks identification | | | | |
| 3: Resource mapping | | | | |
| 4: Accommodation facility assessment | | | | |
| Other? | | | | |
| Will the assessment take into account following areas of health? | | | | |
| Sexual and reproductive health | | | | |
| Sexual and gender based violence | | | | |
| Maternal/child health | | | | |
| Mental health | | | | |
| Non-communicable and chronic diseases | | | | |
| Injuries | | | | |

[4] Insert references: ACAPS – IOM – WHO assessments and situation analysis

| | | | | |
|---|---|---|---|---|
| Communicable diseases and vaccinations | | | | |
| Socio-environmental health | | | | |
| Other? | | | | |
| Will the assessment take into account the following vulnerable groups? | | | | |
| Unaccompanied minors | | | | |
| Children and adolescents | | | | |
| Pregnant women | | | | |
| People with disabilities | | | | |
| Elderly | | | | |
| Undocumented minors | | | | |
| Other? | | | | |

## 2.3 Agents and key resources: participating stakeholders

Intersectoral coordination is important to ensure that health and welfare considerations are optimised in the accommodation and management of migrants in a humanitarian crisis or otherwise stressful situations. Encouragement of and coordination with NGOs and civil society organisations and volunteers who are providing general, non-medical assistance to migrants can promote as healthy an environment as possible.

Intersectoral coordination is also important for maximising access to information about health services and access to the services themselves. Tool A2 provides suggestions on stakeholders to involve during the process and facilitates and overview of how each stakeholder can contribute/participate.

| **TOOL A2: Stakeholder Checklist** | | |
|---|---|---|
| **Potential stakeholders/organisations** | **Identified contact person/ information**<br>*List potential contributors, informants and participants to the assessment* | **Contributions/tasks**<br>*List how each organisation/representative can contribute to and participate in the assessment* |
| Governmental/ National authorities | | |
| Ministry of Health and Social Services<br>Ministry of Immigration<br>Ministry of Justice<br>Ministry of Internal Affairs<br>Other relevant national authorities | | |
| Regional authorities | | |
| Local authorities:<br>Municipality<br>Local hospitals and health care clinics<br>Local police and military authorities | | |
| International organisations | | |
| For example: IRCR, WHO, IOM, UNHCR, UNICEF, ECHO, UCPM, ECDC | | |
| NGOs | | |
| For example: Red Cross, MSF, Health care professionals associations | | |
| Civil society and volunteer organisations | | |

| | | |
|---|---|---|
| LGTB support groups | | |
| Women´s rights groups | | |
| Children´s welfare groups | | |
| Faith based organisations | | |
| Refugees support groups | | |
| Elderly support groups | | |
| Others | | |
| Target group representatives | | |
| Nationality based groups and associations | | |
| Religious groups and leaders | | |
| Others | | |
| Academia | | |
| ? | | |

## 2.4 Sampling methods

Data collection for the assessment of health needs and health protection resources may include gathering of both **secondary data** (existing knowledge) and collection of **primary data** (knowledge generated through interviews, surveys, field visits etc.).

### 2.4.1 Secondary data review

A secondary data review is essential to any assessment to ensure application of existing, updated information on the current crisis of meeting the extensive and diverse health needs of the massive influx of refugees and other migrants to European countries. Data is collected and produced by various agents in the field: at international level in terms of a number of assessment reports, guidelines and recommended actions from international organisations such as WHO, IOM, ECDC, UNHCR, MSF; and, at national level, in terms of country assessment reports and national and sub-national documentations.

To carry out an effective secondary data review specific skills are required:

- Knowledge of main national and international information sources
- Ability to compile, organise and validate large amounts of information
- Ability to summarise and disseminate key points to the stakeholders involved in assessment

These skills must either be ensured within the AT or be hired in by the AT.

**Table 2.1: Selected secondary data ressources** (see annex 1 on for additional information resources within specific health areas)

**Main National and International Information sources**

ACAPS & MapAction (http://www.acaps.org/themes/refugeemigrant-crisis)

- Refugee/Migrant Crisis in Europe - Situation Analysis. January 2016; The Balkan Migrant Crisis - An Introduction. January 2016; Situation Analysis - Transit Country Migrant Crisis. December 2015.

UNHCR http://data.unhcr.org/mediterranean/regional.php)

- Refugees/Migrants Emergency Response – Mediterranean

WHO (http://www.euro.who.int/en/home)

- Assesing health-system capacity to manage large influxes of migrants (Bulgaria, Cyprus, Greece, Malta, Portugal, Serbia, Sicily)

**Assesment guides from national and international sources:**

ICHR

- Framework for the identification of good practices in Sexual & Reproductive Health for Refugees, Asylum seekers and Undocumented Migrants

IOM (https://ec.europa.eu)

- Caring for Trafficked Persons - Guidance for Health Providers.

Save the Children

- Photovoice Guidance – 10 simple steps to involve children in needs assessment

UNFPA (http://gbvguidelines.org/)

- Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience, and Aiding Recovery

UNFPA( http://www.unfpa.org/resources/what-minimum-initial-service-package)

- Minimum initial service package (MISP) for reproductive health

UNHCR

- Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons - Guidelines for Prevention and Response.

UNHCR (http://www.unhcr.org/450e91c14.html)

- The UNHCR Tool for Participatory Assessment in Operations

WHO (http://www.who.int/hac/techguidance/pht/7405.pdf)

- Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations

### 2.4.2 Primary data collection

Primary data must be collected on the basis of existing knowledge, and can be generated through field visits to for example reception centres/hotspots, local stakeholder meetings, interviews, through focus groups, surveys, or by participatory methods.

Primary data collection should focus on recent changes, informal knowledge and information, fillings gaps of information and identifying feasible options for response. Moreover, primary data has the ability to enable the affected populations to participate in identifying the priority of problems and areas of response and contingency planning. When choosing methods for primary data collection it is necessary to consider the expected outcome; if knowledge is needed on services available at a reception centre a field visit including interviews with managers and health personal may be appropriate. If knowledge is needed on how asylum seekers experience health services, focus groups or participatory methods may be more appropriate.[5]

More information on sampling methods for primary data collection can be found in each chapter 3-6 on assessment dimensions.

## 2.5 Writing up the work plan

The final step of the coordination and planning phase is writing the work plan that summarises and contains all decisions made during appointment of assessment team, setting assessment parameters, identifying stakeholders and key resources and choosing sampling methods.

Tool A3 constitutes a sample work plan including main guiding questions to prepare and initiate the next phase of the assessment: data collection. This work plan should be shared by HCT and the AT.

| **TOOL A3: Sample work plan** |
|---|
| Purpose of the assessment |
| • Why is the assessment taking place?<br>• Who will it inform?<br>• How will the information be used? |
| Key assessment questions |
| • What are the health needs and health risks of the target groups?<br>• Which health protection resources are available and accessible to the target groups? |

[5] See for example 'UNHCR Tool for Participatory Assessment in Operations' (UNHCR participatory assessment) or for specific work with children: 'Photovoice guidance - 10 simple steps to involve children in needs assessments' (Save The Children) (Save The Children Photovoice report)

| |
|---|
| • What are the gaps between 1) health needs and risk of the target groups and 2) available and accessible health protection resources? |
| Methodology and approach |
| • How will the assessment adapt to scenario A and B?<br>  ○ Will the assessment primarily focus on immediate, acute care (scenario A); on mediate-/longer term health related issues (scenario B); or both?<br>• Which dimensions of assessment are necessary to include in the assessment?<br>• Which sampling methods will be used? Why and how?<br>• How will the data be validated?<br>• Who will do data collection?<br>• Who will summarise and report data?<br>• How will ethical considerations and potential bias be addressed? |
| Organisation and schedules |
| • How are the assessment team(s) and other involved stakeholders sharing information?<br>• What is the overall timeframe of the assessment?<br>• When are the various dimensions of the dimension carried out?<br>• How will the assessment be reported? How will results be shared? |
| Budget |
| • What are the costs of the assessment and how are these costs financed? |

# PHASE B: Data collection

# 3 SOCIO-DEMOGRAPHIC OVERVIEW – Toolkit I

The purpose of the socio-demographic overview is to obtain updated information on the scope of the situation (including recent and potential developments) and to make ground for awareness to particular groups of people, localities or settings when prioritising and planning further actions and interventions. Furthermore, the purpose is to identify the main characteristics in culture, religious and social organisation of the community at scope, paying attention to relevant differences with the host community.
Data from the socio-demographic overview will be used to estimate health needs and needed resources in the process of planning and prioritising health response as well as for contingency planning.

Regular updates on the numbers of migrants arriving and in transit, their locations and routes of transit are required. Data should be available from the Ministry of the Interior or the government's Migration Agency. Daily and weekly monitoring of the numbers of migrants arriving and leaving, and of the numbers who are present in camps or accommodation facilities at any time should help anticipate significant changes in demands for health services. A basic age and sex breakdown of the migrants will be helpful in order to estimate the health needs and anticipate possible changes in demands, especially from vulnerable groups.

To understand and gain overview of current and anticipated health needs the assessment team must produce a demographic mapping of the current and anticipated groups of refugees, asylum seekers and other migrants in the country in question. An important element of the assessment is the identification of vulnerable groups.

Note: The information is determined by available data on national and sub-national levels

## 3.1 Data collection methods and participating stakeholders

The socio-demographic overview can be developed based on national and international statistics and information (e.g. operational data for the UNHCR[6], UNICEF, UNFPA, OCHA, UNDP, WHO, WFP), but also including recent (potentially informal) records and registrations from immigration authorities, regional, national and international NGOs (including volunteers), police/authorities responsible for security), or from arrival camps. Other sources can be local academics, researchers, teachers, social workers, women's associations and members of the affected and host communities.

Scenario A, especially in emergency situation, needs a rapid assessment and should be organized as quickly as possible during the emergency phase. Statistics are not always available during the crisis; in this situation data collected on this aspect can be simple estimates. Suspicious or inaccurate information should be cross-checked.[7]

The most practical time to register refugees (first level household registration) is when they arrive at a reception/transit centre. If there is no emergency, individual registration (second level registration) is the standard to be achieved within the first 3 months of an influx, this is necessary for camp/center management or voluntary repatriation. Registration is often carried out in conjunction with health screening. Where the formal registration is not possible (emergency, rapid influx), the basic information/estimates should refer to rate of influx and general characteristics of the population and information on origin and destination. In this

6 UNHCR Operational Data Portal: Refugees/Migrants Emergency Response - Mediterranean http://data.unhcr.org/mediterranean/regional.php
7 Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations, WHO Geneva 2001.

case the critical information includes estimates of total population, the population of children under 5 years, proportion of vulnerable groups (ex. women of child-bearing age, elderly etc.).

The following methods can be used to estimate the population:

- counting
- administrative records (if exist), including data from the country of origin
- lists compiled by refugee leaders
- extrapolation including the use of aerial photographs and satellite imagery

Scenario B refers to the next level registration: in the site for settlement, for status determination, local integration and resettlement. This occurs in post-emergency situations so other techniques can be used if the information from previous census or registration exercises is unreliable/insufficient:

- participatory mapping (including cooperation with community leaders),
- household registration.

Systematic observation of the group and trends is recommended.

## Tool 1.1: Socio-demographic mapping

Tool 1.1 below provides suggestions for socio-demographic data that is useful to the further process of prioritising and planning response and preparedness (see SH-CAPAC WP3).

The tool is meant to be flexible; adaptations might be needed to fit the context; there is no one assessment that fits all. Also, not all information called for in this tool will possible to obtain in every situation. Much will depend of the timing of assessment and access to information.

The need for information may be extended in some stages of migration. Asylum seeking stage of migration is an intermediate stage of health needs and risks identification. After receiving asylum and integrating in the society some of the risks will prevail; the records of socio-demographic and health will have much bigger scope and will be available in the national health system.

| **TOOL 1.1: Socio-demographic mapping** | | |
|---|---|---|
| | **Scenario A - Arrival/transit stage of migration** | **Scenario B - Asylum seeking stage of migration** |
| **DEMOGRAPHIC INFORMATION** | | |
| Target population | Records of daily, weekly, monthly registrations of arrivals<br><br>Estimations based on previous patterns should be available<br><br>Records by gender, age,[8] and by number of unaccompanied minors | Records of number of people in asylum centres or other accommodation facilities during asylum seeking process<br><br>Records by age, number of unaccompanied minors, proportion of pregnant and lactating women, proportion of elderly |
| Countries of origin/ethnicity | Records of countries of origin of arrivals | Records of countries of origin of asylum seekers<br><br>Brief history of the country of origin including conflicts, disaster history |

8 (< 1 year), (2- 5 years), (6-10 years), (11-17 years), (18-25 years), (26-49 years), (50-70 years), (70+)

| | | |
|---|---|---|
| Routes of migration<br><br>Records of the routes of migration | Records of countries of departure and transit<br><br>Geographical itinerary, forced displacement cases<br><br>Interruption of water/food supplies during the migration process, weather conditions during the migration process.<br><br>Former difficulties or bad experiences with aid agencies. | Records of countries of departure and transit<br><br>Geographical itinerary, transportation, forced displacement cases; length of stay in poor sanitary conditions when travelling to the host country. Accessibility of health services on previous migration stages.<br><br>Former difficulties or bad experiences with aid agencies. |
| Household | Travelling as the whole family or particular members of the family (in the context of fulfilling social roles) | Records of household structures and size;<br><br>Households headed by women; disruption of the family. |
| Location | Location of the affected population: type ( in/formal camps, transit centres, towns), railway stations, trains, parks), environment (rural, urban, desert, beach etc.), accessibility (easy, difficult, dangerous), sanitary and weather conditions | Location of the affected population: type (camps, centres, towns), environment (rural, urban, desert etc.), accessibility (easy, difficult, dangerous), sanitary and weather conditions |
| Number of granted protected status | | Records by gender, age, and by number of unaccompanied minors |
| Number of arriving quota refugees | | Records by gender, age |
| **SOCIO-ECONOMIC, CULTURE, RELIGIOUS AND POLITICAL INFORMATION** | | |
| Level of education | | Records of educational background, possibility of continuing education |
| Labour market experience | Records of work experience[9] | Records of professional background and labour market experiences |
| Living conditions | Living conditions for children: safe place for sleep, learning, play. | Records of (potential) degradation of living conditions and socio-economic status. Living conditions for children: safe place for sleep, learning, play. |
| Social structure | Records of ethnic composition | Records of clans, tribes, ethnic, existing conflicts; meaning of family (extended family even equal to clan).<br><br>Accepting services organised by people outside the community/clan/tribe. |
| Economic situation | | (Un)employment, management of resources at the family |
| Community characteristics | Self-organisation of the community; existence of any emerging community leaders (what kind? ex. political, ethnic, religious, ex-military, | Strength and resistance before and after conflict, self-organisation of the community; existence of any emerging community leaders |

9 These recordings can be useful in planning and coordinating targeted efforts – it is useful to have information on not only tendencies in the state of health of arriving refugee, asylum seekers and other migrants, but also potential professionals backgrounds, as the social resources of these people can be of use and great significance already in arrival/transit situations.

| | | |
|---|---|---|
| | ex-freedom fighters?) | (what kind? ex. political, ethnic, religious, ex-military, ex-freedom fighters?), disruption of previous community structure.<br><br>Community disharmony (conflicts, violence, schisms). |
| Coping skills and behaviour | | Brief history of the relationship between host, refugee and displaced groups; cohesion and solidarity in the community |
| Religion and tradition | Religion, matri/patrilineal community, existence of traditional healers, taboos, traditions and rituals | Religion, matri/patrilineal community (traditional gender roles), existence of traditional healers, taboos, traditions and rituals; relevant cultural attitudes towards health services. |
| Languages spoken and communications skills | Records of languages spoken; communications in different society structure | Records of languages spoken and experiences with interpretation; communications in different society structure |
| **HEALTH** | | |
| SRH | Records of pregnant and lactating women; by age and household position | Records of pregnant and lactating women; by age and household position |
| Mental Health | Records of mental health treatments; prevalence of refugees with possible tortures and war /disaster experiences.<br><br>Records of self-reported mental health status.<br><br>Records of medicines for diseases requiring immediate treatment.<br><br>Local ways of describing emotional difficulties. | Records of mental health treatments; prevalence of refugees with possible tortures and war/disaster experiences<br><br>Records of self-reported mental health status;<br><br>Community reaction to mental illness and problems. Attention paid to the fact that mental problems can be manifested as physical complaints. Local ways of describing emotional difficulties.<br><br>Records of medicines for diseases requiring immediate treatment. |
| Chronic diseases | Records of self-reported chronic diseases and illnesses.<br><br>Records of malnutrition among new arriving refugees.<br><br>Records of medicines for diseases requiring immediate treatment (ex. insulin) | Records of self-reported chronic diseases and illnesses; prevalence of tobacco smokers etc.; inadequate nutrition in country of origin and during the travel; attention paid to inaccurate data from country of origin due to lack of health care services (ex. health facilities destroyed).<br><br>Records of medicines for diseases requiring immediate treatment (ex. insulin) |
| Disabilities | Records of physical and psychological disabilities | Records of physical and psychological disabilities (including self-reported), meaning/treatment and considering of disability in the affected community.<br><br>Demands for prosthesis etc. |
| Vaccination | Records of immunizations status of children | Records of immunizations status of children, proportion of children with confirmed/supposed vaccination. Reliability of the records from war/conflicts/poor areas. |
| Communicable Diseases | Records of reported CD. Records of medicines for diseases requiring immediate treatment. | Records of reported CD; susceptibility of the population. Records of medicines for diseases |

| | | |
|---|---|---|
| | | requiring immediate treatment. |
| **ENTITLEMENTS** | | |
| Entitlement to health care services | Existence and awareness of the state regulations related to different entitlements/conditions associated with varying migrant status, especially in emergency situations. | Existence and awareness of the state regulations related to different entitlements/conditions associated with varying migrant status; existing training for managers/practitioners.<br><br>Attention should be paid to nuances for e.g what constitutes emergency care (different service providers may apply different definitions)/ the decision of what constitutes a medical emergency is usually left to the provider.<br><br>Role of NGOs as important service providers that compensate for the lack service pro-vision structures within the public health system.<br><br>Role of development of the whole health system in the hosting country as an important factor for the real access to services. |
| Entitlement to medications | Existence and awareness of the state regulations related to different entitlements/conditions associated with varying migrant status, especially in emergency situations; coverage of vulnerable groups. | Existence and awareness of the state regulations related to different entitlements/conditions associated with varying migrant status; existing training for managers/practitioners/pharmacists; coverage of vulnerable groups. |
| Housing | Existence of state regulations on safe housing; WASH. | Existence of state regulations on safe housing and WASH; NGO activities in the area. |
| Right to work | | Existence of state regulations on entitlements and conditions. |
| Right to education and pleasure for children | | Existence of state regulations, NGO activities. |
| Financial support | | Existence of state regulations, social assistance system in the host country. |

## Tool 1.2: Resources: Stakeholders and information sources

Doing a socio-demographic mapping requires various information resources. Tool 1.2 suggests selected resources; others may be available or more adequate in a given country context.

| **TOOL 1.2: Resources: Stakeholders and information sources** | |
|---|---|
| **Participating stakeholders** | |
| Central and regional national authorities | Ministries responsible for: health, education, social welfare, interior, external affairs, migration etc<br>other/ ad hoc central/district offices<br>local refugee offices<br>local UN administration<br>security authorities<br>refugee community<br>non-state entities<br>other relevant authorities |
| Representatives of agencies, associations, services universities | Central UN administration in country<br>UN agencies |

| | |
|---|---|
| | NGO's (international, regional, local)<br>religious groups, spirituals community, religious leaders<br>indigenous/traditional healers<br>cultural anthropologist/sociologist<br>health professionals and relevant associations<br>women's, youth, disabled, minority groups or associations |
| Intersectoral sources | teachers (different level) and academic staff<br>cultural, youth, sport and social groups<br>clan, village camp, community leaders<br>representatives of the elderly<br>police, army, other security forces |

**Information resources: overviews and monitoring of migration trajectories**

EC, European Commission (http://ec.europa.eu/)

- Managing the Refugee Crisis. State of play and future actions, January 2016
- Eurostat Statistics

IFRC, International Federation of Red Cross and Red Crescent Societies (http://www.ifrc.org/)

- Information Bulletin IFRC Regional Office for Europe Migration response.

IOM, International Organization for Migration (http://www.iom.int)

- Global Migration Data Analysis Centre.

FRA, European Union Agency for Fundamental Rights (http://fra.europa.eu/en)

- Monthly data collection on the current migration situation in the EU.

MdM, Médecins du Monde, (Doctors of the World) (http://www.medecinsdumonde.org/) (https://doctorsoftheworld.org/)

- Crossing Borders: MdM's Response to the Migrant and Refugee Crisis

REACH, Informing more effective humanitarian action (http://www.reach-initiative.org/)

- Situation Overview: European Migration Crisis

UNHCR, United Nations High Commissioner for Refugees (http://www.unhcr.org/cgi-bin/texis/vtx/home)

- Refugees/Migrants Emergency Response - Mediterranean
- Subregional operations profile - Northern, Western, Central and Southern
- Regional Refugee and Migrant Response Plan. Eastern Mediterranean and Western Balkans Route. 2016

# 4 NEEDS AND RISKS IDENTIFICATION – Toolkit II

The purpose of Toolkit II to identify health needs of and health risk to the target population in the given country context by:

- describing the state of health of asylum seekers and refugees in a required setting (e.g. (sub)national setting);
- enabling the identification of the major risk factors and causes of ill health; and
- enabling the identification of the actions needed to address these.

A needs and risks assessment is not a one-off activity but a continuous developmental process that is added to and amended over time. It is not an end in itself but a way of using information to plan health care and public health programmes in the future.

Objectives of the assessment include reaching agreement on:

- the most critical health problems, gaps and risks at different stages of flight (see annex 1 for a review of health needs and recommendations for health protection);
- the criteria for the prioritization of attention to health problems and ensuring that the criteria are recorded and understood by everyone. Some health areas may be prioritized above others. For example, mental health needs are necessary to explore in the settlement phase (scenario B) but this may not be possible in the arrival/transit phase (scenario A);
- a prioritized list of problems that is updated whenever needed;
- the specific opportunities and constraints that influence health status and the delivery of health services taking account of how the overall situation is expected to evolve; and
- take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation.

## 4.1 Data collection methods and participating stakeholders

The contextual identification of health needs and health protection resources can be carried in different ways. We present here two main ways:

***1: Continuous meetings with stakeholders***

The assessment team invites stakeholders for continuous (e.g. weekly) meetings to discuss the needs of asylum seekers/refugees as well as possible barriers in the organisation of health care. The meetings can be organized at local or regional level, for example with all relevant stakeholders in the region of a reception centre such as regional hospitals, GPs, pharmacies, the Red Cross, municipalities and (non-)governmental organisations responsible for the reception and health care of asylum seekers. Preferably, representatives of asylum seekers/refugees are also invited. Responsibility for team leadership and reporting must be clearly identified. The meetings can be led by a member of the assessment team or by a member of a national or regional governmental organization or by someone from the health coordination team to keep the overview. In the meetings problems and barriers are discussed and prioritized and possible solutions are shared. If necessary more or less meetings can be arranged (e.g. monthly, bimonthly).

### *2: Interviews and/or focus groups with representatives*

The assessment team (or representatives from the team) invites representatives for individual or focus group interviews. Representatives can include national health professionals working in centres, camps, in health services, NGOs, administration, migrant clinics, specialized care etc. and should certainly contain people from the target population (e.g. refugees granted protected status or someone who have a background as refugee to the country). ). The assessment team should be aware that the representatives of target population should reflect the target population as much as possible, and be aware of bias in that direction.

The team decides the representatives for the interviews. In some countries the interviews can benefit from being regional or local, in some countries it can make sense to have interviews addressing the arrival/transit phase (i.e. focus on arrival and asylum) and other interviews addressing the settlement phase (i.e. focus on general health services system).

**Table 4.1 Recommendations for interview recruitment**

- Representatives may be government officials, health personnel, social workers, teachers, leaders/members of local and international non-governmental organisation, leaders/members of informal groups (asylum seekers/refugees)
- Representatives should cover the various areas of health being:
  - Specialized in certain health areas (e.g. SGBV, maternal health, child health, communicable diseases
  - Specialized in working with particular vulnerable groups; such as unaccompanied minors (e.g. from foster care organisations, paediatricians, youth care workers)
  - Working at different levels of health care (GPs, hospital, mental health care) and at different institutional levels (managers, doctors, nurses)
  - From national level (MoH), subnational level, local level, NGOs, civil society
  - From the target population both recently arrived (as in within the last 2 years) and people who have long-term settled in the country after arriving as refugee
  - Responsible for housing / accommodation conditions (municipal officers, housing organisations)
  - From local communities in host countries
  - Responsible for coordination of reception centres, hotspots

*Notice: Representatives are often the more vocal, better off, better-educated, and more powerful members of the group, which can introduce a bias. They may not represent the views of the more vulnerable in the society.*

**Steps to carry out a contextual needs and risks assessment are**:

1. **Profiling**
   - Collection and analysis of relevant information that will inform the AT about the state of health and health needs of the asylum seeker/refugee population (See paragraph 4.1)
2. **Deciding on priorities for action** (See paragraph 4.3)

## TOOL 2.1: Key information guide to assess contextual health needs and risk factors

In order to collect relevant information about the contextual health needs and risks factors of the asylum seeker/refugee population, tool 4.1 can be used as a guide to what information the qualitative data collection is able to provide.

| **TOOL 2.1: Key information guide to assess contextual health needs and risk factors** | | | | |
|---|---|---|---|---|
| Key question | Dimensions | | | |
| | Impact | Vulnerabilities | Trends | Information gaps |
| What are the main health needs* of the target group in the particular context/setting? | What are the consequences when these health needs are unmet? | Which groups within the target population stand particular vulnerable? | How are these health needs likely to involve in the given context/setting? (extent, severity, change) | Which information is yet lacking to take action? |
| What are the main risk factors to the health and wellbeing of the target group in the particular context/setting | What are the consequences when these health needs are unmet? | Which groups within the target population stand particular vulnerable? | How are these risk factors likely to involve in the given context/setting? (extent, severity, change) | Which information is yet lacking to take action? |
| **Health needs must be considered in different health areas: SRH, SGBV, M/C health, mental health, NCD, CD and vaccinations, injuries, socio-environmental health* | | | | |

## TOOL 2.2: Key Question Guide on health needs and health risks

A thematic question guide can support the collection of information and is based on identified knowledge on health needs of asylum seekers/refugees/other migrants in different stages of the migration. The AT develops the question guide based on a set of general, open questions to be addressed in a focus group or interview. The general questions allow health professionals, managers and others stakeholders working in the field to express how they in the specific context experience health needs and availability/effectiveness of health protection resources. Tool 2.2 gives suggestions for basic questions to guide the interview/focus group/meeting.

**TOOL 2.2: Key Question Guide on health needs and health risks**

- Which major health needs do you find among the target group you are working with?
  - Please consider following areas of health: SRH, SGBV, M/C health, mental health, NCD, injuries, CD and vaccination, socio-environmental health.
  - How are these health needs met among the target group you are working with?
- Which risk factors do you find increasing the vulnerability of the target group you are working with?
  - Please consider following areas of health: SRH, SGBV, M/C health, mental health, NCD, injuries, CD and vaccination, socio-environmental health.
- Which protective factors do you find strengthening the health and wellbeing of the target group you are working with? How?
  - Which agents can affect/enable these protective factors? How?
  - Are there any (potential) obstacles to these protective factors?

The objective of the interviews is to identify health needs and available resources in specific health areas (mental health, maternal/child health, SRH, SGBV, chronic/non-communicable diseases, communicable diseases/vaccination, environmental health) addressing different phases of migration (first arrival/transit/asylum seeking/settlement) according to national contextual relevance. A qualitative approach is appropriate as it provides concrete descriptions of how people experience a given issue. It provides information about the "human" side of an issue – that is, the often contradictory behaviours, beliefs, opinions,

emotions, and relationships of individuals. A qualitative approach aims to answer questions about "what", "how" or "why". It is important that the AT has some understanding of the rules of (qualitative) research in order to collect and analyse meaningful health information.

Two common qualitative methods are focus group interviews and individual interviews. Focus groups are an effective way of eliciting broad (and diverse) views and perspectives, whereas individual interviews are good for collecting in-depth data on expert knowledge and/or individuals' perspectives. A combination of both types of interviews can also be used. See table 4.4 for reflections on when and where to use the methods.

**Table 4.2 Qualitative data collection methods**

**Focus groups – Strengths**

- Relatively efficient way of gaining a large amount of information
- Stimulates discussion and sharing of opposing or controversial views
- Stimulates spontaneity and can be emotionally provocative
- Statements can have a 'snowball effect' → standpoints are deepened

**Focus groups – Weaknesses**

- Control over interview can be difficult
- Interview is guided by group norms → standpoints may be concealed or watered down
- Interview is guided by group behavior e.g. by dominant respondents or hidden agendas, gender or ethnic differences may also play a role
- Difficult for discussing sensitive issues (e.g. SGBV) or ethical issues

**Individual interviews – Strengths and weaknesses**

Individual interviews have as strengths that control is easier and that the interview is less guided by group norms. As a weakness individual interviews need more time.

**More information on qualitative data collection**

- Miles MB, Huberman M. Qualitative Data Analysis: A methods sourcebook. London: Sage, 2014.
- Medecins sans Frontieres. Assessment Toolkit. Practical steps for the assessment of health and humanitarian crises. Vienna: MSF, 2012, https://evaluation.msf.org/sites/evaluation/files/assessment_toolkit.pdf

## 4.2 Deciding on priorities for action

To identify and decide on priorities for action table 5.6 can be used. Table 5.6 offers guidelines to weight the collected information about health needs and risks.

**Table 4.3 Identifying priorities**

- Compare identified health needs with international benchmarks (e.g. EU standards for the reception of applicants for international protection)
- Compare with pre-crisis situation or neighbouring country levels
- Risk of mortality, morbidity or disability
- Urgency – immediacy of risk
- Number of people directly at risk
- Feasibility of addressing and having a measurable impact in the short term
- Contribution of action to improving the health system and protecting public health

# 5 HEALTH SERVICES MAPPING AND ASSESSMENT – Toolkit III

**The purpose** of toolkit III is to map and assess to what extent health services are meeting the needs of migrants.
The mapping and assessment can be conducted by using all five tools, or selecting some of them:

- Tool 3.1 to assess the knowledge and interpretations of migrant entitlements to care by health care providers and managers;
- Tool 3.2 to map primary health care facilities and their capacity;
- Tool 3.3 to assess availability of primary health care services;
- Tool 3.4 to assess availability of secondary health care services;
- Tool 3.5 to assess access to and the quality of those health care services for migrants.

**Objectives**: After having identified the health needs and risks of migrants (see Toolkit II), the tools for 'health services mapping and assessment' help to identify:

- What is understood by health care providers and managers regarding the health care entitlements of different groups of migrants to whom they provide care;
- Gaps in the provision of services intended to meet the health care needs of migrants;
- Problems in delivery of those services or in access to them.

## 5.1 Data collection methods

Toolkit III contains tools for quantitative and qualitative mapping of the availability of health care services for refugees, asylum seekers and other migrants and the effectiveness of these services in terms of access and quality. Recommended approaches for collecting information for tools 3.1, 3.3 and 3.5 include individual semi-structured interviews and focus group discussions (See Table 4.2 on FG and Interview as sample method). Tools 3.2 and 3.4 should be completed by the assessment team or by at least one observer from their team. For some tools preparations beforehand by the respondent may be desired, e.g. to get correct numbers of number of staff.

For the purpose of mapping and assessing the health services provided, **individual interviews** may be the best way of collecting necessary information from:

- Providers of specialised care to migrants, e.g. mental health or sexual and gender-based violence;
- Specialists working with particular vulnerable groups like unaccompanied minors;
- Representatives of residents' advisory boards at local accommodation centres;
- Senior government officials, heads of local or regional reception programs, or heads of international or national NGOs; and/or
- Persons in charge of health facilities for using tools 3.2 and 3.4 in scenario A.

**Focus group discussions** (FGDs) stimulates discussions of different viewpoints. Where health facilities are exclusively providing care to migrants, it may be most efficient to make up the focus group from providers of the different services within the facility and to jointly complete tools 3.1, 3.3 and 3.5. However, where migrants are getting care from facilities that also provide care to the local population, it may be better to make up the group from several facilities that serve significant numbers of migrants. In this case, it might be best to have

different groups for providers caring for different types of health issues, for example, sexual and reproductive health, child health, adolescent (general and non-communicable diseases), and mental health.

| Tool | Purpose | Scenario A | Scenario B |
|---|---|---|---|
| **Tool 3.1** | Assess knowledge and interpretations of migrant entitlements to care | Interview with person in charge of the health facility; If time allows focus group discussion | Focus group discussion with health care providers |
| **Tool 3.2** | Map primary health care facilities and their capacity | Interview with person in charge of the health facility | |
| **Tool 3.3** | Assess availability of primary health care services | Short version of the tool > data obtained from health facility manager(s) or one or two health care providers;<br>Complemented with focus group discussion | Long version of the tool > data obtained from health facility managers or one or two health care providers;<br>Complemented with focus group discussion |
| **Tool 3.4** | Assess availability of secondary health care services | Interview with senior doctor(s) or the hospital manager of the hospital | |
| **Tool 3.5** | Assess access to and quality of health care services for migrants | Focus group discussion with health care providers | Focus group discussion with health care providers |

**Follow-up investigations:** It is possible that initial interviews or FGDs identify gaps or problems that need some further investigation because the exact nature of the problem is not clear. Usually clarification can be achieved by further interviews or FGDs with either health staff involved, a specialist, or some groups of representative migrants. Often these key informants come up with solutions that are both feasible and acceptable to the people involved.

## TOOL 3.1: Tool to assess knowledge and interpretation of migrants' entitlements to care by health care providers and managers

The purpose of this tool is to assess the knowledge and interpretation of the national migrants' health care entitlement regulations by health care providers and managers. This assessment gives background to tools 3.3 and 3.5 which assess the availability and quality of and access to different health care services for migrants because it gives an idea of the expectations that refugees, asylum seekers and other migrants might have when they know what services they are entitled to.

Under the time constraints of completing the health services mapping and assessment in the case of Scenario A countries, the respondent may just be the person in charge of the health facility. In Scenario B, this tool will probably be completed by organising focus groups to discuss this tool, together with tools 3.3 and 3.5.

The interviewer or facilitator of the focus group discussion should be well prepared by having the government's latest regulations about health care entitlements of different groups of migrants and explaining them (see first action of the tool). In case of a focus group: the names of participants and affiliation should be displayed so that all participants see the information.

| **TOOL 3.1: Stepwise checking of knowledge and interpretation of migrants' entitlements to care by health care providers and managers** | | |
|---|---|---|
| **Steps** | **Date:** | **Name of health facility:**<br>**Name of respondent:** |
| | **Actions and required resources** | |
| **1** | Have available the government's latest regulations that give details of the national health care entitlements of different groups of migrants | |
| **2** | Show Article 19 on health care for asylum seekers of the 2013 directive from the European Parliament to which the country is a signatory:<br>*Health care*[10]<br>1. *Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and serious mental disorders.*<br>2. *Member states shall provide necessary medical or other assistance to applicants who have special reception needs*[11]*, including appropriate mental health care, where needed.*<br>Write out this article on a large sheet of paper or on several small pieces of paper that you can hand out, or display it on a screen/tablets. | |
| **3** | Ask the respondents or FGD participants to identify the legal status of the migrants to whom they are providing care | |
| **4** | Ask each respondent/participant to describe the health care entitlements of these migrants that they provide health care to<br>! in case of FGD: to avoid influence by other group members, ask them to write the information down on pieces of paper or *post-it* notes, which you then collect and read out | |
| **5** | Read out the relevant sections of the government regulations, and ask the respondents/focus group to discuss how well perception matches regulations | |
| **6** | Show the respondents/focus group again the wording of the European Parliament on health care for asylum seekers and ask them whether this changes the way they understand either a) the government regulations, or b) the scope of care to be provided to migrants | |

## TOOL 3.2: Tool for inventory of primary health care facilities

This tool is designed specifically for Scenario A, where large numbers of migrants are arriving across borders and moving through one location. The purpose is to help the local health coordinator to conduct an inventory of the primary health care facilities or service points that are caring for migrants in what may be a humanitarian crisis situation.

These primary health care facilities may be state-owned or set up by national or international NGOs, or volunteer groups. They may be static or mobile primary care facilities, or they may be first aid or service points on a beach or at a train station. If the influx of migrants changes (e.g. increase or decrease), it is possible that the 'supply' of health services delivery changes too, so it is important to regularly update the inventory of

[10] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast).

[11] Special reception needs are defined in article 21 as "minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illness, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation.

primary health care facilities. The best source of information is the person in charge of the (current) primary health facility.

| **TOOL 3.2: Inventory of primary health care facilities** | | |
|---|---|---|
| | **Date:** | **Name of health facility:**<br>**Name of respondent:** |
| | **Questions** | **Responses** |
| 1 | Type of facility | *e.g. Mobile/Static; Permanent/Temporary; First aid/Basic package of primary health care services* |
| 2 | Ownership/management | *e.g. State-owned/national NGO/international NGO/volunteers* |
| 3 | Funding source | *e.g. National government (state budget); NGO; Health insurance; Private funding* |
| 4 | Funding amount | *e.g. Envelope of x€; x€ per patient* |
| 5 | Location/Address/GPS | |
| 6 | Number of outpatient consulting rooms | |
| 7 | Number of day beds | |
| 8 | Laboratory availability and services provided | |
| 9 | Key staff: *number of doctors* | F:<br>M: |
| 10 | Key staff: *number of nurses* | F:<br>M: |
| 11 | Key staff: *number of midwives* | F:<br>M: |
| 12 | Number of full-time equivalent interpreters | F:<br>M: |
| 13 | Drugs & supplies | *(i.e. capacity of essential drugs and supplies in terms of days)* |
| 14 | Vaccines | *(i.e. availability of vaccines and cold chain)* |
| 15 | Source(s) and frequency of resupply | *(i.c. resupply of drugs, medical supplies and vaccines)* |
| 16 | Referral agreements and arrangements | |
| 17 | Transportation availability | |
| 18 | Transportation arrangements | |
| 19 | Any particular expectations or constraints of the facility? | |
| 20 | Committed to being part of the health coordination team? | |

## TOOL 3.3: Tool to assess availability of primary health care services

The purpose of this tool is to assess the availability of services at primary health care facilities or their capacities to provide them. Specific gaps in services are identified where desired or intended services are absent or only partly available.

Tool 3.3 can be used in both Scenario A (shorter version) and Scenario B (longer version). In the left hand column there are items that are shaded in yellow: these are the additional items that are included in the longer version for use in Scenario B, where migrants (asylum seekers and refugees) are expected to stay for a longer period.

- In Scenario A, where migrants are usually present for a short time and rarely attend the health facility more than once, we recommend using the basic tool without the additional (dark shaded) items. The health facilities and service points in Scenario A, run by a mix of government, non-government and volunteer organisations, will, almost certainly, not all be providing comprehensive primary health care, so it is important to document the services that are actually provided by each of them. This allows the local health coordinator/assessment team to ensure that appropriate referral links and communication systems are established. Information needed to assess the availability can be obtained from the health facility managers or one or two health care providers.
- In Scenario B, health needs that were not met while migrants continued traveling can now receive attention and therefore services provided to asylum seekers and refugees who seek to settle or stay long time in the country need to be available. Also, longer-term health issues like pregnancy, non-communicable diseases and mental disorders can now have specific care programs established because they represent health needs that have been regularly identified in migrant populations. These are the additional items that are shaded dark yellow in tool 3.3.

Information to assess availability of the primary health care facilities is best collected by a short straightforward survey beforehand and further detailed by means of FGDs. It is important to get consensus from the focus group whether a specific service is available, partially available or not available in the area. If a gap in health care services is identified during the focus group discussion, it is important to ask the focus group participants for possible solution to close the gap.

| **TOOL 3.3: Availability of primary health services** | | | | |
|---|---|---|---|---|
| **Health services requirements** | **Availability of service** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| General clinical services and physical trauma care<br>1. Outpatient services<br>2. Triage (four colour system)<br>3. First aid and basic resuscitation<br>4. Injury care (open wounds, fracture immobilization) | | | | |
| Child Health<br>1. Management of acute childhood illnesses<br>2. Screening for and outpatient management of malnutrition<br>3. EPI: Routine immunisations<br>4. Growth and developmental monitoring and advice | | | | |
| Communicable diseases | | | | |

| TOOL 3.3: Availability of primary health services | | | | |
|---|---|---|---|---|
| **Health services requirements** | **Availability of service** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| 1. Sentinel site of early warning system of epidemic-prone diseases<br>2. Individual, family and community management of scabies and skin infections, lice and intestinal helminths<br>3. Diagnosis and management of TB | | | | |
| STIs and HIV/AIDS<br>1. Investigation and management OR syndromic management of STIs<br>2. HIV counselling and testing<br>3. Standard precautions<br>4. Availability of free condoms<br>5. Sexual health promotion | | | | |
| Sexual and reproductive health of minors<br>1. Age and culturally-appropriate sexual health promotion for minors<br>2. Access to family planning counselling and contraceptives for adolescents | | | | |
| Maternal and newborn care<br>1. Family planning counselling and provision of contraceptives<br>2. Abortion care<br>3. Nationally approved protocols for antenatal care<br>4. Skilled care in childbirth for a clean and safe delivery (24/7)<br>5. Emergency obstetric care, appropriate to type of facility, or referral (24/7)<br>6. Essential newborn and postpartum maternal care (24/7)<br>7. Sufficient female staff (particularly if clients are Muslim)<br>8. Health promotion program about goals and recommended schedules for pregnancy care<br>9. HIV counselling and testing, and PMTCT as indicated | | | | |
| Sexual and gender-based violence<br>1. Holistic management of rape survivors (medical, psychosocial and forensic)<br>2. Emergency contraception<br>3. Post-exposure prophylaxis for STIs and HIV<br>4. Tetanus and Hepatitis B vaccination<br>5. Specifically-trained SGBV staff and awareness of all staff of the signals and symptoms of SGBV for referral<br>6. Publicity at accommodation facilities (near the health facility) about location of services for SGBV<br>7. Registration of SGBV cases | | | | |
| Non-communicable diseases<br>1. Management of acute problems of diabetes, asthma, hypertension and other NCDs<br>2. Individual assessment and implementation of standard management and follow-up protocols for hypertension, diabetes, asthma, chronic obstructive airways disease, etc. | | | | |

| TOOL 3.3: Availability of primary health services | | | | |
|---|---|---|---|---|
| **Health services requirements** | **Availability of service** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| 3. Provision of nutrition and dietary advice that helps with the transition to use of a different mix of available foods and food preparations | | | | |
| Mental health<br>1. Support of acute distress and anxiety<br>2. Management of severe and common mental disorders<br>3. Treatment for the damage caused to persons who have been subjected to torture, rape or other serious acts of violence, in particular access to appropriate medical and psychological treatment or care<br>4. Implementation of screening tests by primary care providers to help identify conditions like PTSD and depression that are especially common among migrants from conflict zones who survived SGBV<br>5. Access to rehabilitation services for minors who have been the victims of any form of abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts; appropriate mental health care and qualified counselling is provided when needed<br>6. Screening of children, especially unaccompanied minors, for PTSD, depression and SGBV, in primary care facility or at school<br>7. Established protocols for mental health care at primary level and for referral to specialised mental health units with language and cultural interpretation capacity<br>8. Culturally and linguistically-appropriate information programs about symptoms and "warning signs" of mental health problems and where to seek help | | | | |
| Environmental health<br>1. Safe management and disposal of health facility waste<br>2. Procedures for the management of accidents with infected materials | | | | |
| Health providers and administrators<br>1. Trained in appropriate cultural competencies<br>2. Trained and provided with copies of confidentiality guidelines<br>3. Trained in the health risks and exposures, physical and mental, of migrants from particular countries or regions<br>4. Trained on risk factors, signals and symptoms of SGBV | | | | |
| Language and culture mediators<br>1. Trained for medical consultations<br>2. General purpose interpreters | | | | |
| Client satisfaction and feedback<br>1. An established mechanism to regularly measure client satisfaction and obtain feedback on services | | | | |

## TOOL 3.4: Tool to assess availability of secondary health care services

The purpose of this tool is to help the local health coordinator to assess and monitor the capacity of the local hospital to provide secondary care services that are needed in the arrival/transit and asylum seeking migration stage. Information should be obtained from the senior doctor(s) or the hospital manager of the hospital.

| **TOOL 3.4: Availability of secondary health services** | | | | |
|---|---|---|---|---|
| **Health services requirements** | **Availability of services** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| General clinical services and physical trauma care<br>1. Presence of specialised doctors, including at least one general surgeon<br>2. OPD with surgical triage<br>3. Inpatient services (medical, paediatrics and obstetrics & gynaecology wards)<br>4. Trauma and surgical care. (At least one surgical theatre, with or without gas anaesthesia)<br>5. Post-operative rehabilitation for trauma-related injuries.<br>6. Laboratory services<br>7. Blood bank service<br>8. Basic radiology unit | | | | |
| Child health<br>1. Management of children classified as severe or very severe disease (i.e. parenteral fluids and oxygen available)<br>2. Management of severe malnutrition with medical complications | | | | |
| Maternal and newborn care<br>1. Comprehensive emergency obstetric care<br>2. Management of sick and premature newborns | | | | |
| Mental health<br>1. Outpatient psychiatric care and psychological counselling<br>2. Acute psychiatric in-patient care | | | | |

## TOOL 3.5: Tool to assess access to and the quality of health services

The purpose of this last tool is to complement the specific questions of tool 3.3 and 3.4 with general questions about access to and quality of the health services provided so that gaps and problems can be identified. It is probably best to complete the list of questions in this tool when closing the focus group discussions for tool 5.3. However, it would also be valuable to have input from both health managers and representatives (male and female) of the migrants at an accommodation centre or of migrant associations among those granted refugee status. Complementary interviews with these key informants about access to and quality of health care services should therefore be considered. Selected results from recent surveys using this tool in ten European countries are shown in table 5.1 below.

**TOOL 3.5: Tool to assess access to and the quality of health care**

- What are any challenges for your health service related to the migrant crisis?
- How do they impact your work as a health care provider?
- How do they impact your work as a health care manager?
- What particular barriers are affecting access to care for the migrants?
- Which groups of migrants do these barriers or difficulties particularly affect?
- What particular problems are affecting the quality of care?
- Which factors could potentially facilitate access?
- Which factors could potentially increase effectiveness?

**Table 5.1 Typical recent problems identified by health staff providing care for asylum seekers, refugees and other migrants**

| **Scenario A: Arrival/Transit Countries** | **Scenario B: Destination Countries** |
|---|---|
| The number of migrants challenge capacity of health services<br>• Lack of health facilities where migrants arrive or transit<br>• Insufficient primary health care providers or social workers<br>• Insufficient mental health professionals<br><br>Hospital emergency facilities swamped because:<br>• Migrants do not know where to go or what they are entitled to,<br>• Lack of coordination of national, NGO and volunteer primary care services with emergency services.<br><br>Quality of care challenged because:<br>• Lack of language and cultural interpreters<br>• Lack of training in cultural competence for staff<br>• Absence of health and vaccination records<br>• Frequently no opportunity for follow-up care<br>• Short hospital stays to keep up with travel companions<br>• Lack of familiarity with certain health problems or the presentation of mental health problems<br><br>Vulnerable groups<br>• Management of unaccompanied minors<br>• Care for pregnant women<br><br>Health conditions in camps<br>• Overcrowding and exposure leading to nutritional, gastrointestinal and skin problems<br>• Sexual and gender-based violence<br>• Repressive police and army personnel.<br><br>Identification and burial of dead bodies. | Complexity of administrative procedures for access to care, different procedures depending on status of the migrant, and frequent long delays in the registration process.<br>• Confusion on the part of health managers and providers<br>• Stress on providers because of the legal restrictions on types of care.<br>• Access wrongly denied to migrants on occasions.<br>• Information provided to migrants often inadequate.<br><br>Quality of care issues<br>• Resources of primary care facilities near reception centres may be inadequate if large numbers of migrants seeking care.<br>• Lack of language and cultural interpreters<br>• Lack of training in cultural competence for staff<br>• Lack of female health staff for caring for women.<br>• Lack of health and vaccination records<br><br>Sexual and reproductive health<br>• Access to pregnancy and delivery care according to status of migrant<br>• Sexual and gender-based violence is said to be common among asylum seekers, both women and young men<br><br>Mental Health<br>• Inadequate capacity to care for the large number of traumatised refugees among asylum seekers.<br>• Difficulties in distinguishing between physical, psychological and social issues. |

***Source**: SH-CAPAC project WP4. In order to gather information on the new challenges for health services related to the current refugee crisis a series of interviews and focus groups with health providers and managers and social services staff have been conducted in 10 EU countries between February and March 2016: Austria, Belgium, Italy, Spain, Greece, Hungary, Slovenia, Netherland, UK and Denmark (for more information and details on results see WP4 report on resource packages)*

# 6 ACCOMMODATION FACILITY ASSESSMENT – Toolkit IV

The purpose of toolkit 4 is to help health authorities to assist those in charge of migrants' accommodation facilities in ensuring that an acceptable standard of general health and SGBV protection, safety and security is guaranteed and maintained in the facilities, in order to comply with the European Directive laying down minimum standards for the reception of applicants for international protection and the Minimum Standards for Humanitarian response.[12]

## 6.1 Data collection methods

The recommended methods to collect the required information are to conduct field visits and interviews at accommodation centres.

### TOOL 4.1: General health protection at accommodation centres

The purpose of this tool is to help health authorities to assist those in charge of migrants' accommodation facilities to ensure that an acceptable standard of **general health protection, safety and security** is maintained in the facilities.

The tool is intended as a simple checklist of areas of concern to public health and safety, including water, sanitation and hygiene.[13] It elaborates on areas that have been identified as those of significant concern in other similar situations.

The assessment is appropriately carried out by a senior health manager and a senior health inspector appointed by the authorities and linked to the health coordination team (or other person familiar with national standards for institutional health and safety) in collaboration with the persons in charge of the facility. A meeting with representatives of the migrants is recommended. In order to ensure that the concerns and perspectives of women are heard, meetings with men and women separately are considered.

| **TOOL 4.1: Assessment of general health protection at accommodation facilities** | | | | |
|---|---|---|---|---|
| **Health protection requirements for accommodation centres at border or transit zones and other reception accommodation centres** | **Degree of standard compliance** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| Water supply, sanitation and hygiene promotion<br>1. Hygiene promotion:<br>• hand washing,<br>• showers,<br>• personal hygiene (see also non-food items)<br>2. Water quantity and access<br>3. Toilets: quantity, privacy and security<br>4. Solid waste management<br>5. Drainage<br>6. Vector control | | | | |
| Food security and nutrition | | | | |

[12] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down minimum standards for the reception of applicants for international protection (recast). *Official Journal of the European Union, 29.6.2013.*

[13] Inspired by the Sphere Project, 2011. Humanitarian Charter and Minimum Standards in Humanitarian Response.(www.sphereproject.org).

| TOOL 4.1: Assessment of general health protection at accommodation facilities | | | | |
|---|---|---|---|---|
| **Health protection requirements for accommodation centres at border or transit zones and other reception accommodation centres** | **Degree of standard compliance** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| 1. Daily food provision that meets or passes standards of minimum nutrition requirements<br>2. Reliable supply of age-appropriate, nutritionally adequate, safe complementary foods for infants and young children and the means to prepare them hygienically | | | | |
| Shelter, security and settlement<br>1. Guaranteeing an adequate standard of living<br>2. Guaranteeing protection of family life<br>3. Taking into consideration gender and age-specific concerns and the situation of vulnerable persons<br>4. Appropriate security measures to prevent assault and sexual and gender-based violence, including lighting and separate, internally lockable washing and toilet facilities | | | | |
| Non-food items<br>1. Clothing<br>2. Bedding<br>3. Household items:<br>• Soap, laundry soap and personal hygiene materials, including infant nappies (diapers) and provision for menstrual hygiene, and information on the use of any materials that are unfamiliar<br>• Stoves, fuel<br>• Food preparation and cooking utensils<br>• Eating utensils<br>• Light source | | | | |
| Minors<br>1. Ensure access to leisure activities, including play and recreational activities appropriate for their age and to open-air activities | | | | |
| Staffing and management<br>1. Persons working in accommodation centres shall be adequately trained and shall be bound by the confidentiality rules provided for in national law in relation to any information they obtain in the course of their work<br>2. Applicants are involved in managing the material resources and non-material aspects of life in the accommodation centre through an advisory board or council representing residents<br>• Male representative(s)<br>• Female representative(s) | | | | |

## TOOL 4.2: SGBV protection at the accommodation facilities

The purpose of this tool is to help health authorities to assist those in charge of migrants' accommodation facilities to ensure that the requirements for **prevention and management of the consequences of sexual and gender-based violence** as forwarded in the European Directive laying down minimum

standards for the reception of applicants for international protection[14] and in the IASC[15] guidelines for SGBV prevention and response in humanitarian settings are implemented.[16]

The following articles on SGBV in the European Directive lay down minimum standards for the reception of asylum seekers:

- *Article 17.2: Member States shall ensure that material reception conditions provide an adequate standard of living for applicants, which guarantees their subsistence and protects their physical and mental health.*
- *Article 18.4: Member States shall take appropriate measures to prevent assault and gender-based violence, including sexual assault and harassment, within the premises and accommodation centres.*
- *Article 19.2: Member States shall provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care where needed.*
- *Article 21: Member States shall take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation, in the national law implementing this Directive.*
- *Article 25.1: Member States shall ensure that persons who have been subjected to torture, rape or other serious acts of violence receive the necessary treatment for the damage caused by such acts, in particular access to appropriate medical and psychological treatment or care.*
- *Article 25.2: …and shall be bound by the confidentiality rules provided for in national law, in relation to any information they obtain in the course of their work.*

The tool is intended as a simple checklist of areas of concern related to SGBV. The assessment is appropriately carried out by an SGBV expert, a senior health manager or a senior health inspector appointed by the authorities and the health coordination team with SGBV training background in collaboration with the persons in charge of the facility. A meeting with representatives of the migrants is recommended. In order to ensure that the concerns and perspectives of women are heard, meetings with men and women separately are considered.

| **TOOL 4.2: Assessment of SGBV protection at accommodation facilities** | | | | |
|---|---|---|---|---|
| **SGBV Protection requirements for accommodation centres at border or transit zones and other reception accommodation centres** | **Degree of standard compliance** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| Prioritise SGBV risk reduction activities in camp planning and set-up<br>1. Safety issues when selecting site locations so that camps do not exacerbate GBV vulnerability (e.g. proximity to national | | | | |

[14] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down minimum standards for the reception of applicants for international protection (recast). *Official Journal of the European Union, 29.6.2013.*

[15] IASC, GPC. Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience, and Aiding Recovery. 2015.

[16] Keygnaert I., Vangenechten J., Devillé W., Frans E. & Temmerman M. (2010) Senper¬forto Frame of Reference for Prevention of SGBV in the European Reception and Asylum Sector. Magelaan cvba, Ghent. ISBN 978-9078128-205.

| TOOL 4.2: Assessment of SGBV protection at accommodation facilities | | | | |
|---|---|---|---|---|
| **SGBV Protection requirements for accommodation centres at border or transit zones and other reception accommodation centres** | **Degree of standard compliance** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| borders, competition for natural resources, presence of armed groups/forces) are considered<br>2. Sphere standards to reduce overcrowding, which can lead to stress and enhance the risk for intimate partner violence/domestic violence are adhered to<br>3. The natural resource base of the area and their accessibility routes during camp planning and site selection are evaluated as safe<br>4. Reception areas for new arrivals are equipped with a private room where a SGBV specialist can provide referrals for immediate care of victims<br>5. Safety and privacy in non-collective sleeping areas through the provision of intrusion-resistant materials, doors and windows that lock from the inside and – where culturally appropriate – internal partitions are assured<br>6. Where collective centres are the only option, appropriate family and sex-segregated partitions (paying due attention to the rights and needs of LGBTI persons who may make up non-traditional family structures and/or to be excluded from sex-segregated spaces) are put in place<br>7. Secured separated male and female washing areas, provide adequate lighting and door locks from inside are ensured<br>8. Safe and nurturing environments in which children and/or adolescents can access free and structured play, recreation, leisure and learning activities are ensured<br>9. Temporary separate housing for unaccompanied children until a foster care situation can be arranged is arranged for<br>10. The camp is designed and laid out in consultation with women, adolescent girls and other at-risk groups<br>11. Culturally competent community outreach material including basic information about SGBV risk reduction is available and disseminated | | | | |
| Refugee registration respects the vulnerable<br>1. Married women, single women, single men, and girls and boys without family members are registered individually<br>2. Individuals with different gender identities are able to register in a safe and non-stigmatizing way | | | | |
| Capacity building of staff on SGBV<br>1. Health workers are sensitised on suspect features as unexplained bruising, fractures, trouble walking or sitting, excessive emotions, extremes in behaviour, attachment troubles, STD or pregnancy in young children<br>2. Health workers are trained on cultural practices, expected behaviours and social norms that constitute SGBV and/or increase risk of SGBV against girls and boys (e.g. preferential treatment of boys; child marriages; female genital mutilation/cutting; gender-based exclusion from education; | | | | |

| TOOL 4.2: Assessment of SGBV protection at accommodation facilities | | | | |
|---|---|---|---|---|
| **SGBV Protection requirements for accommodation centres at border or transit zones and other reception accommodation centres** | **Degree of standard compliance** | | | **Suggested action(s)** |
| | **No** | **Part** | **Full** | |
| domestic responsibilities for girls; child labour; recruitment of children into armed forces/groups; etc.)<br>3. Health workers are trained to talk about and react appropriately on SGBV including referral | | | | |
| Prevention of violence from professionals (police, military personnel, humanitarian workers…)<br>1. A Code of Conduct against exploitation and abuse (SEA) is put in place<br>2. An SGBV prevention and response policy is implemented<br>3. An internal complaint system is installed<br>4. Punishments and legal action are installed | | | | |
| Provision of medical support to female and male victims<br>1. The safety and accessibility of existing SGBV-related health services (e.g. safety traveling to/from facilities; cost; language, cultural and/or physical barriers to services, especially for minority groups and persons with disabilities; existence of mobile clinics; etc.) are assured<br>2. Private consultations are assured<br>3. First aid kits are available:<br>• Post-rape treatment kit: levonorgestrel, antibiotics (azithromycin, cefixime…), Lamivudine/Zidovudine, pregnancy test, bag, guidelines and checklists<br>• Suture of tears/vaginal examination kit: chlorhexidine, polyvidone iodine, lubricant, sutures, compress, gloves, mayo scissors, needle holder, retractor, speculum, forceps, tray<br>4. Easy access to emergency contraception, PEP, wound care, tetanus and hepatitis B prevention are assured | | | | |
| Provision of psychosocial support<br>1. First psychological aid is provided to victims of acute sexual violence and psycho-education on normal psychological reactions to the victimisation is given to them and their peers<br>2. Watchful waiting is applied until 1 month after the sexual victimisation<br>3. Confidential counselling by trained psycho-social workers are offered when mental health problems persevere after 1 month<br>4. Support groups and group activities for female and male victims are organised | | | | |
| Response system to handle complaints<br>1. Confidential and blame free reporting is assured<br>2. Reports of sexual exploitation and abuse are handled quickly and properly<br>3. Possible legal procedures are explained to victims<br>4. If desired, victims are referred for legal assistance | | | | |

# PHASE C: Reporting

# 7 SUMMARISING RESULTS: To take the next step into planning for action

All gathered information and data should be reported to the HCT in order to facilitate shared information with all relevant stakeholders. Based on this shared ground of information first steps can be taken by stakeholders, particularly to health authorities at national, regional and local levels to develop national action plans to implement a public health response and strengthen country health systems under the pressure of a massive influx of refugees, migrants and asylum seekers.

Tool C1 can be of assistance in the task of outlining an overview of the main conclusions of the assessment of health needs and available health protection resources. The intention is not to complete the matrix but to make a collected, brief overview of the main results from assessments carried out in one or more assessment dimensions.

| **Tool C1: Summary and main conclusions framework** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | **Assessment dimensions** | | | | **Overall conclusions** | | |
| **Key question** | *Health area* | Highlighted findings Socio-demographic overview | Highlighted findings Needs and risks identification | Highlighted findings Resource mapping | Highlighted findings Accommodation facility assessment | Identified knowledge gaps | General conclusions | Suggestions for action (from informants) |
| **What are the <u>unmet</u> health needs of the target population ? (Incl. awareness to main <u>health risks</u>)** | *SRH* | | | | | | | |
| | *SGBV* | | | | | | | |
| | *M/C health* | | | | | | | |
| | *Mental health* | | | | | | | |
| | *NCD* | | | | | | | |
| | *Injuries* | | | | | | | |
| | *CD/vaccination* | | | | | | | |
| | *Socio-environmental health* | | | | | | | |
| **Which health protection resources are <u>not</u> available and accessible to the target population ?** | *SRH* | | | | | | | |
| | *SGBV* | | | | | | | |
| | *M/C health* | | | | | | | |
| | *Mental health* | | | | | | | |
| | *NCD* | | | | | | | |
| | *Injuries* | | | | | | | |
| | *CD/vaccination* | | | | | | | |
| | *Socio-environmental health* | | | | | | | |

During the meetings, focus groups and interviews knowledge gaps are likely to occur. When knowledge gaps are identified, the assessment team can suggest further studies or research to develop more in-depth knowledge on specific elements/conditions/needs as an integrated part of planning and strategy development. This potential data collection can be carried out through field visits, case studies, interviews, participatory research methods. This data collection should include consulting of national professionals, specialists and front personnel relevant to the specific field.

For detailed information, guidelines and tools in regard to developing strategic action plans and contingency planning please refer to SH-CAPAC WP3 report on development of action plans.

# ANNEXES

- Information on risk factors by scenario A and B, including list of references for further information.
- Health areas included: SRH, SGBV, M/C health, Mental health, NCD and chronic diseases, injuries, CD and vaccinations, socio-environmental health.

| **SEXUAL AND REPRODUCTIVE HEALTH** | | |
|---|---|---|
| | **Scenario A - Arrival / transit** | **Scenario B – Asylum seeking/ settling** |
| **STD/HIV TRANSMISSION AND CARE** | | |
| **Risk factors** | Level of risk dependant on region of origin of asylum seekers with Middle East currently displaying a lower risk than Sub-Saharan Africa<br>- No continuity in HIV treatment<br>- Risk of HIV infection through unprotected sex and SGBV | - Fear of reporting HIV infection in order not to affect the asylum claim.<br>- Risk of HIV infection through unprotected sex and SGBV |
| | Poverty, separation from a spouse, social and cultural norms, language barriers, substandard living conditions and exploitative working conditions, including sexual violence, engaging in risky behaviours because of separation and stress; inadequate access to HIV services and fear of being stigmatized. | |
| **Vulnerable groups** | Women and girls, MSM, patients needing transfusion | |
| **SRH OF MINORS** | | |
| **Risk factors** | - Lack of hygiene augmenting risk of urinary tract infections and infections of genitals<br>- Lack of access to contraception<br>Risk of SGBV, unwanted pregnancy and STI's especially the unaccompanied minors being taken out of their protective group they were travelling with | - Lack of culturally sensitive sexual health promotion activities<br>- Lack of access to family planning services<br>- Risks of SGBV, unwanted pregnancy and STI's<br>- Lack of awareness of healthcare providers on cultural practices as FGM, early marriages |
| **Vulnerable groups** | Minors, especially unaccompanied, minors who were sexually victimised, adolescents with unmet need for contraception, adolescents having reached culturally appropriate age of marriage. | |

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| **SEXUAL AND GENDER-BASED VIOLENCE (SGBV)** | | |
|---|---|---|
| | **Scenario A - Arrival / Transit** | **Scenario B – Asylum seeking/ settling** |
| **PREVENTION** | | |
| **Risk factors** | - Lack of protection in (overcrowded) refugee camps or registration centres<br>- Separation of unaccompanied minors from their protective group because of law<br>- Growing number of refugees living in urban and other non-camp settings<br>- Extreme stress<br>- Lack of social control<br>- Lack of justice<br>- Violence from professionals (police, military personnel, humanitarian workers,…) | - Unsafe infrastructure of reception facilities<br>- Lack of prevention policy<br>- Lack of code of conduct of staff and asylum seekers<br>- Lack of competences in staff to recognize risk factors, signals and symptoms of SGBV<br>- Lack of culturally sensitive awareness raising and prevention activities<br>- Lack of implementation of EU directive of Minimum Standards of Reception<br>- Lack of participation and leadership of female asylum seekers in lay-out infrastructure and prevention policy and measures<br>- Increasing stress of asylum procedure and process leading to domestic violence, child abuse and sexual violence<br>- Unequal attention to female and male asylum seeker empowerment<br>- Lack of possibility to be intimate in private for couples<br>- Previous untreated victimisation and or traumatisation. |
| **Vulnerable groups** | Girls, boys, adolescents and young adults, unaccompanied minors and adults travelling alone, women, LGBTI | |
| **HOLISTIC CARE FOR VICTIMS OF SGBV** | | |
| **Risk factors** | At the level of the migrant:<br>- Lack of knowledge on potential ill-health consequences if not treated<br>- No time for treatment in order to be able to register and/or move on with the group<br>- Lack of knowledge on availability of treatment possibilities<br>- Lack of familiarity with the health care system<br>- Fear of reporting SGBV in order to avoid separation of or repercussion by other group members<br>- Fear of not receiving culturally appropriate care or miscomprehension of/judgement on cultural practices<br><br>At the level of the registration and reception facilities: | At the level of the migrant:<br>- Lack of knowledge on potential ill-health consequences if not treated<br>- Lack of knowledge on availability of treatment possibilities<br>- Lack of familiarity with the health care system<br>- Fear of reporting SGBV in order to avoid separation of or repercussion by other group members or supposed impact on asylum claim<br>- Fear of not receiving culturally appropriate care or miscomprehension of/judgement on cultural practices<br><br>At the level of the reception facilities: |

| SEXUAL AND GENDER-BASED VIOLENCE (SGBV) | | |
|---|---|---|
| | **Scenario A - Arrival / Transit** | **Scenario B – Asylum seeking/ settling** |
| **PREVENTION** | | |
| **Risk factors** | - Lack of protection in (overcrowded) refugee camps or registration centres<br>- Separation of unaccompanied minors from their protective group because of law<br>- Growing number of refugees living in urban and other non-camp settings<br>- Extreme stress<br>- Lack of social control<br>- Lack of justice<br>- Violence from professionals (police, military personnel, humanitarian workers,…) | - Unsafe infrastructure of reception facilities<br>- Lack of prevention policy<br>- Lack of code of conduct of staff and asylum seekers<br>- Lack of competences in staff to recognize risk factors, signals and symptoms of SGBV<br>- Lack of culturally sensitive awareness raising and prevention activities<br>- Lack of implementation of EU directive of Minimum Standards of Reception<br>- Lack of participation and leadership of female asylum seekers in lay-out infrastructure and prevention policy and measures<br>- Increasing stress of asylum procedure and process leading to domestic violence, child abuse and sexual violence<br>- Unequal attention to female and male asylum seeker empowerment<br>- Lack of possibility to be intimate in private for couples<br>- Previous untreated victimisation and or traumatisation. |
| **Vulnerable groups** | Girls, boys, adolescents and young adults, unaccompanied minors and adults travelling alone, women, LGBTI | |
| | - Lack of competences in staff to recognize and discuss signals and symptoms of SGBV in general<br>- Lack of competences in staff to recognize and discuss signals of harmful cultural practices as FGM, forced marriages and honour-related violence<br>- Lack of availability of specialised staff, infrastructure (e.g. mobile clinics) and equipment to provide emergency SGBV treatment<br>- Lack of capacity in staff to apply the principles of child-friendly care when engaging with girl and boy survivors<br>- Lack of awareness in staff on how to safely and confidentially document cases of SGBV | - Lack of competences in staff to recognize and discuss signals and symptoms of SGBV in general<br>- Lack of competences in staff to recognize and discuss signals of harmful cultural practices as FGM, forced marriages and honour-related violence<br>- Lack of knowledge of staff on where to refer to for holistic care<br>- Lack of capacity in staff to apply the principles of child-friendly care when engaging with girl and boy survivors<br><br>At the level of the health facilities:<br>- Lack of safety and accessibility of existing SGBV-related health services (e.g. safety traveling to/from facilities; cost; language, cultural and/or physical barriers to services, especially for minority groups and persons with disabilities; existence of mobile clinics; etc.)<br>- Lack of affordable care<br>- Lack of entitlement to care for undocumented migrants<br>- Lack of competencies of specialized staff in the provision of holistic (= medical, psychosocial and forensic) care for victims<br>- Lack of competencies in staff to treat SGBV victims in culturally competent way as well as to treat victims with specific culturally-related health problems as a history of FGM, risk of honour-related violence<br>- Lack of specialised sexual assault referral centres or treatment units providing holistic care<br>- Gaps in services for girl and boy survivors (including child-friendly health care; mental health |

| SEXUAL AND GENDER-BASED VIOLENCE (SGBV) | | |
|---|---|---|
| | **Scenario A - Arrival / Transit** | **Scenario B – Asylum seeking/ settling** |
| **PREVENTION** | | |
| **Risk factors** | - Lack of protection in (overcrowded) refugee camps or registration centres<br>- Separation of unaccompanied minors from their protective group because of law<br>- Growing number of refugees living in urban and other non-camp settings<br>- Extreme stress<br>- Lack of social control<br>- Lack of justice<br>- Violence from professionals (police, military personnel, humanitarian workers,…) | - Unsafe infrastructure of reception facilities<br>- Lack of prevention policy<br>- Lack of code of conduct of staff and asylum seekers<br>- Lack of competences in staff to recognize risk factors, signals and symptoms of SGBV<br>- Lack of culturally sensitive awareness raising and prevention activities<br>- Lack of implementation of EU directive of Minimum Standards of Reception<br>- Lack of participation and leadership of female asylum seekers in lay-out infrastructure and prevention policy and measures<br>- Increasing stress of asylum procedure and process leading to domestic violence, child abuse and sexual violence<br>- Unequal attention to female and male asylum seeker empowerment<br>- Lack of possibility to be intimate in private for couples<br>- Previous untreated victimisation and or traumatisation. |
| **Vulnerable groups** | Girls, boys, adolescents and young adults, unaccompanied minors and adults travelling alone, women, LGBTI | |
| | | and psychosocial support; security response; legal/justice processes; etc.)<br>- Lack of awareness in staff on how to safely and confidentially document cases of SGBV and how to provide court testimony when appropriate |
| **Vulnerable groups** | Girls, boys, adolescents and young adults, unaccompanied minors and adults travelling alone, women, men being overlooked as potential victims, LGBTI | |


Frans E. & Keygnaert I. (2009) Make it Work! Training Manual for Prevention of SGBV in the European Reception & Asylum Sector. 150 pp, Academia Press, Ghent. *ISBN 978 90 382 1575 4*.

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| SEXUAL AND GENDER-BASED VIOLENCE (SGBV) | | |
|---|---|---|
| | **Scenario A - Arrival / Transit** | **Scenario B – Asylum seeking/ settling** |
| **PREVENTION** | | |
| **Risk factors** | - Lack of protection in (overcrowded) refugee camps or registration centres<br>- Separation of unaccompanied minors from their protective group because of law<br>- Growing number of refugees living in urban and other non-camp settings<br>- Extreme stress<br>- Lack of social control<br>- Lack of justice<br>- Violence from professionals (police, military personnel, humanitarian workers,…) | - Unsafe infrastructure of reception facilities<br>- Lack of prevention policy<br>- Lack of code of conduct of staff and asylum seekers<br>- Lack of competences in staff to recognize risk factors, signals and symptoms of SGBV<br>- Lack of culturally sensitive awareness raising and prevention activities<br>- Lack of implementation of EU directive of Minimum Standards of Reception<br>- Lack of participation and leadership of female asylum seekers in lay-out infrastructure and prevention policy and measures<br>- Increasing stress of asylum procedure and process leading to domestic violence, child abuse and sexual violence<br>- Unequal attention to female and male asylum seeker empowerment<br>- Lack of possibility to be intimate in private for couples<br>- Previous untreated victimisation and or traumatisation. |
| **Vulnerable groups** | Girls, boys, adolescents and young adults, unaccompanied minors and adults travelling alone, women, LGBTI | |

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| MATERNAL AND CHILD HEALTH | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| **ANTENATAL, INTRAPARTUM AND POSTPARTUM CARE** | | |
| **Risk factors** | - Lack of safe and hygienic labour and delivery setting (e.g. no trained staff, no clean delivery kits)<br>- Lack of care for complications (e.g. no referral system to hospital if caesarean or blood transfusion would be necessary, no transportation means available)<br>- Wish to continue the journey may lead to non-attendance of antenatal nor postnatal | - Factors for worse maternal health outcome in pregnant migrant women include: low socio economic status, gestational diabetes mellitus/high body mass index, congenital factors, foeto-pelvic disproportion, inadequate antenatal care, lack of familiarity or comprehensibility of maternal health services<br>- Some national regulations and legislations restrict access to maternal care services |

| MATERNAL AND CHILD HEALTH | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| | consultations, limited attention to postpartum depression<br>- Poor or delayed gynaecological care because of lack of information, language/communication barriers, strict gender roles (e.g. no male gynaecologist allowed) or financial barriers | - Poor or delayed gynaecological care because of lack of information, language/communication barriers, strict gender roles (e.g. no male gynaecologist allowed) or financial barriers<br>- Chronic stress related to migration experiences, asylum procedures, precarious living conditions, heavy work during pregnancy and integration problems impact maternal health |
| **Vulnerable groups** | Adolescent pregnant girls, women (travelling alone), foetuses, newborns. | |
| **NEWBORN AND CHILD HEALTH** | | |
| **Risk factors** | - Inadequate nutrition may lead to low birth weights<br>- No track record of newborn or child vaccinations<br>- Inadequate nutrition may lead to low birth weights<br>- No track record of newborn or child vaccinations | - Higher newborn and child mortality rates because of factors associated with the migration process, socio-cultural factors, different lifestyle, low quality housing |
| **Vulnerable groups** | Newborns. Children. | |
| **FAMILY PLANNING AND CONTRACEPTION** | | |
| **Risk factors** | Unattended pregnancies because no use or inavailability of preferred family planning methods during journey<br>Unattended pregnancies because no use or inavailability of preferred family planning methods during journey | Unemployment, need to support families and poverty expose migrant women to trafficking, to sex work or forced labour where risks of sexual violence, sexually transmitted infections and unwanted pregnancy increase |
| **Vulnerable groups** | Minors, adolescents with unmet need for contraception, adolescents having reached culturally appropriate age of marriage. | |

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| MENTAL HEALTH | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| **DEPRESSION** | | |
| **Risk factors** | Symptoms severity could be predicted by cumulative traumatic events | - It may be rather the burden of current stress and lack of resources than traumatic stress, that leads to depression<br>- Symptoms severity could be predicted by lack of refugee status |
| | Depression is often comorbid with PTSD (many refugees might have symptoms of various torture-related problems, including depression, posttraumatic stress disorder, panic attacks, chronic somatic symptoms and suicidal behaviours). Based on the current available evidence from higher-quality studies it is estimated that 8-25% of refugees in high-income countries are affected by depression, with most of them additionally having PTSD. | |
| **Vulnerable groups** | Survivors of torture[17], Older refugees, Women, People exposed to traumatic events, Detainees<br>According to study about asylum seekers in Serbia by Vukčević et al. (2014) the nationals from Afghanistan are more depressed and Somalis are less depressed than the respondents from other countries. | |
| **SUICIDAL BEHAVIOUR** | | |
| **Vulnerable groups** | Survivors of torture, Females, Detainees | |
| | According to Ikram & Stronks (2016): psychosis and suicide (attempts) among refugees and asylum seekers require attention. The researchers mentioned the systematic review written by Kalt et al., were it was found that suicides and suicidal attempts were nearly two times more common in asylum seekers than the host population in high-income countries. | |
| **POSTTRAUMATIC STRESS REACTIONS** | | |
| **Risk factors** | - traumatic events (being close to death, forced separation from family members, murder of family or friend, threatened to be physically tortured, being tortured, imprisonment, SGBV<br>- trauma domains (human rights abuses, traumatic losses, lack of necessities, separation from others)<br>Time in detention is positively associated with severity of distress | Post-traumatic stress reactions could be aggravated by:<br>- asylum process<br>-the stress of settling to a new culture, living in poverty, meeting intolerance and racism lack of resources<br>- unemployment, weak social network, weak social integration into the society and weak social integration in the immigrant ethnic group<br>- past (potentially traumatic) experiences and present distress and adjustment difficulties<br>-<br><br>The protective factors are: high social support (including family reunion), practicing religion, parental disclosure, host language proficiency, access to culturally competent mental health services etc. |
| **PTSD** | | |
| **Risk factors** | - exposure to fighting and hostility<br>- history of trauma before the conflict<br>SGBV | Symptom severity of PTSD and depression was significantly associated with lack of refugee status and accumulation of traumatic events<br>- untreated SGBV experiences |
| | Could be comorbid with other psychiatric disorders, like for e.g. anxiety disorders, depression or agoraphobia. | |
| | - prevalence rates of PTSD were identified, from 36% to 62%, among adult refugees (from 41% to 76%, among children).<br>- among refugees living in four camps at the southern Turkish border the prevalence of the | It is estimated, that 13-25% of the refugees resettled in high-income countries suffer from PTSD. |

[17] Providing mental health services with specialized staff for survivors of torture should be a priority, particularly in areas with high concentrations of Syrian refugees (Hassan et al., 2015)

| MENTAL HEALTH | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| | following mental health was reported: 61% PTSD; 53% anxiety; and 54% depression. | |
| **Vulnerable groups** | - Survivors of torture and SGBV, children, people exposed to traumatic events, Detainees<br>- Asylum seekers from the Middle East are especially prone to develop post-traumatic stress syndrome, due to living in war and war-like conditions<br>- The nationals of Syria suffer from PTSD considerably more than asylum seekers from other countries (Vukčević et al., 2014) | |
| **AGGRESSION OR TEMPER TANTRUMS (SHOUTING, CRYING, AND THROWING OR BREAKING THINGS); NERVOUSNESS, HYPERACTIVITY AND TENSION; SPEECH PROBLEMS OR MUTISM** | | |
| **Risk factors** | Experience of: conflict, first-hand destruction of their homes and communities, surviving forced displacement, family separations, exposure to physical, psychological and sexual violence, recruitment by armed groups, lack of access to basic services. | Separation from friends, families and neighbours, and lack of basic services, increases the likelihood that children will be exposed to violence in their homes, communities and schools |
| **Vulnerable groups** | Children with disabilities, chronic diseases or from single parent families | |
| **SUBSTANCE USE DISORDERS** | | |
| **Risk factors** | Addictions to drugs, alcohol, prescribed medicines. There is limited data on the use of alcohol and other psychoactive substance in displaced populations from Syria, but it might be anticipated that they might be prone to addictions. (Hassan et al., 2015). For example: a study among Syrian refugees to Iraq found that about half of the respondents had more than five alcoholic drinks per week. | |
| **Vulnerable groups** | Males, victims of SGBV | |
| **PROLONGED GRIEF DISORDER** | | |
| **Risk factors** | Loss and grief (for deceased family members, but also for emotional, relational, or material losses) are central issues for most refugees. The emotional problems could be compounded by daily stressors. | |
| **Vulnerable groups** | All | |
| **PERPETRATION OF DOMESTIC AND SEXUAL VIOLENCE** | | |
| **Risk factors** | - extreme stress<br>- lack of social control<br>- lack of protective structures<br>- lack of justice | - De-professionalisation, feeling of not being useful in the society, accessibility of work and socio-economic difficulties<br>- Previous untreated victimisation and or traumatisation<br>- Lack of availability to be intimate with partner or to find a partner<br>- Unequal attention to female and male asylum seeker empowerment |
| **Vulnerable groups** | Male, adolescents, previously victimised and traumatised migrants having (had) no access to care and which are exposed to prolonged stress | |
| **OTHER MENTAL DISORDERS**<br>**Disorders of Extreme Stress Not Otherwise Specified (DESNOS)**, **Panic attacks, Anxiety, Medically unexplained somatic symptoms**, **Schizophrenia** | | |
| **Risk factors** | - Disorders of Extreme Stress Not Otherwise Specified (DESNOS) could be comorbid with other psychiatric disorders like for e.g. panic disorder, social phobia, generalized anxiety disorder (GAD), or PTSD<br>- Misdiagnosis of schizophrenia due to lack of awareness of migrants' culture and norms) | |
| **Vulnerable groups** | All | |
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| MENTAL HEALTH | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |


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| MENTAL HEALTH | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| Mental Health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the Move in Europe - MHPSS-refugees-asylum-seekers-migrants-Europe-Multi-Agency-guidance-note.pdf [WWW Document], n.d. URL http://www.euro.who.int/__data/assets/pdf_file/0009/297576/MHPSS-refugees-asylum-seekers-migrants-Europe-Multi-Agency-guidance-note.pdf?ua=1 (accessed 3.5.2016).<br><br>Pfortmueller, C.A., Schwetlick, M., Mueller, T., Lehmann, B., Exadaktylos, A.K. (2016) Adult Asylum Seekers from the Middle East Including Syria in Central Europe: What Are Their Health Care Problems? PloS One 11, e0148196.<br><br>Quosh, C., Eloul, L., Ajlani, R., (2013) Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review, Intervention 3, p. 276-294.<br><br>Raphaely, N. and E. O'Moore. (2010) Understanding the Health Needs of Migrants in the South East Region. Health Protection Agency and Department of Health, London.<br><br>Robjant K., Hassan R (2009) Mental health implications of detaining asylum seekers: a systematic review. The British Journal of Psychiatry, 194, 306-312<br><br>Teodorescu, D.-S., Heir, T., Hauff, E., Wentzel-Larsen, T., Lien, L. (2012) Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. Scand. J. Psychol. 53, 316–332.<br><br>Vukčević, M., Dobrić, J., Purić, D. (2014) Study of the mental health of asylum seekers in Serbia [WWW Document]. UNHCR. URL http://www.unhcr.rs/media/MentalHeallthFinal.pdf (accessed March 3th 2016).<br><br>Wells, R., Wells, D., Lawsin, C. et al. (2015) Understanding psychological responses to trauma among refugees: The importance of measurement validity in cross-cultural settings, Journal and Proceedings of the Royal Society of New South Wales. p. 60. | | |

| NON-COMMUNICABLE AND CHRONIC DISEASES | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| **CARDIOVASCULAR DISEASES** | | |
| **Risk factors** | | - Complex nature of migration and resettlement and the surrounding social and psychological conditions (poor socioeconomic status, everyday living and working conditions)<br>- Alterations in family life and chronic stress related to insecurity and homesickness<br>- Poor dietary adaptation<br>- Poor access to healthcare services and their underutilisation<br>- Other diseases and health problems |
| **Vulnerable groups** | | Prevalence is high in Syrian refugees population |
| **ARTHRITIS** | | |
| **Risk factors** | Travel and/or living conditions | Living and working conditions, homesickness, damages |
| **Vulnerable groups** | Elderly, women<br>Elderly, women | Elderly, women |
| **CHRONIC RESPIRATORY DISEASES** | | |
| **Risk factors** | Tobacco smoking | Living and working conditions, tobacco smoking, air quality |
| **Vulnerable groups** | Tobacco smokers (second-hand included) | Tobacco smokers (second-hand included) |
| **DIABETES** | | |
| **Risk factors** | Poor access to healthcare services and lack of continuity of care | Nutrition transition, physical inactivity, gene-environment interaction, stress, ethnic susceptibility<br>Poor access to healthcare services<br>lack of continuity of care |
| **Vulnerable groups** | People with diabetes in family history, pregnant women | People with diabetes in family history, pregnant women |

| NON-COMMUNICABLE AND CHRONIC DISEASES | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |

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| INJURIES[18] | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| **TORTURE** | | |
| **Risk factors** | Exposure of refugees to torture in own country, eg, beating of the soles ++[19] | |
| **Vulnerable groups** | Children | |
| **SELF-INFLICTED INJURIES** | | |
| **Risk factors** | Higher suicide death risk ++[3] | |
| **Vulnerable groups** | Males | |
| **OTHER INJURIES** | | |
| **Risk factors** | +[3] | +[3] |
| | Burns may be an increasing risk in humanitarian camps and asylum seeker centres. | |
| **Vulnerable groups** | Children | Children |


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[18] There is limited information on the health situation of the refugees currently in Europe.

[19] ++ means high attention needed, + means attention needed, +/- means if possible attention needed.

| INJURIES[18] | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
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| COMMUNICABLE DISEASES AND VACCINATIONS[20] | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| **TUBERCULOSIS** | | ++ |
| **Risk factors** | The social and economic vulnerability of the refugee population | |
| **MALARIA** *(Plasmodium vivax malaria)* | | ++ |
| **Risk factors** | Transmission could occur when environmental conditions may become permissive (high temperature) and if similar migration patterns prevail | |
| **LOUSE-BORNE RELAPSING FEVER (LBRF)** | + | ++ |
| **Risk factors** | Populations living in crowded and unsanitary conditions | |
| **TYPHOID FEVER, SCABIES, AND CHOLERA** | + | + |
| **Risk factors** | The conditions in crowded camps (where the minimum requirements of safe water and sanitation are not met) | |
| **UNDERVACCINATION** | +/- | ++ |
| **INFLUENZA** | + | |
| **Risk Factors** | Refugees are at risk of acquiring influenza in reception camps and during their journey. | |
| European Centre for Disease Prevention and Control (2015) Expert Opinion on the public health needs of irregular migrants, refugees or asylum seekers across the EU's southern and south-eastern borders. Stockholm: ECDC; 2015. http://ecdc.europa.eu/en/publications/Publications/Expert-opinion-irregular-migrants-public-health-needs-Sept-2015.pdf<br><br>European Centre for Disease Prevention and Control (2015) Communicable disease risks associated with the movement of refugees in Europe during the winter season – 10 November 2015, Stockholm: ECDC; 2015. http://ecdc.europa.eu/en/publications/Publications/refugee-migrant-health-in-european-winter-rapid-risk-assessment.pdf<br><br>European Centre for Disease Prevention and Control (2015 c). Rapid Risk assessment. Risk of importation and spread of malaria and other vector-borne diseases associated with the arrival of migrants to the EU [WWW Document], n.d. URL http://ecdc.europa.eu/en/publications/_layouts/forms/Publication_DispForm.aspx?List=4f55ad51-4aed-4d32-b960-af70113dbb90&ID=1393 (accessed 4.26.16).<br><br>Sondén K, Castro E, Trönnberg L, Stenström C, Tegnell A, Färnert A. (2014) High incidence of Plasmodium vivax malaria in newly arrived Eritrean refugees in Sweden since May 2014 Eurosurveillance, 19 (35) 04 September<br>WHO/Europe \| Migration and health - Migration and health: key issues [WWW Document], n.d. URL http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european- | | |

[20] In spite of the common perception of an association between migration and the importation of infectious diseases, there is no systematic association. Communicable diseases are associated primarily with poverty. Migrants often come from communities affected by war, conflict or economic crisis and undertake long, exhausting journeys that increase their risks for diseases that include communicable diseases.

| COMMUNICABLE DISEASES AND VACCINATIONS[20] | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| region/migration-and-health-key-issues#292117 (accessed 4.26.16).<br><br>WHO-UNHCR-UNICEF. WHO-UNHCR-UNICEF Joint Technical Guidance: General Principles of Vaccination of Refugees, Asylum-Seekers and Migrants in the WHO European Region. | | |

| SOCIO-ENVIRONMENTAL HEALTH | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| **ENVIRONMENT** | | |
| **Risk factors** | - Lengthy and unsafe travel in overcrowded boats exposes migrants to physical and psychological trauma, dehydration, nutritional disorders, hypothermia and infectious diseases<br>- Malnutrition<br>- Overcrowded arrival settlements<br>- Inadequate water and sanitation systems<br>- Overcrowding in migrant centres can facilitate the transmission of infectious diseases, including acute respiratory infections and diarrhoeal diseases.<br>Crowding living conditions can promote the transmission of HIV/AIDS, tuberculosis and skin infections such as scabies<br>- Lack of privacy<br>- Unfamiliar climate, diet and hygiene.<br>- Poor hygienic conditions.<br>- Poor working conditions<br>- Lack of basic amenities. | - Crowding living conditions.<br>- Unfamiliar climate, diet and hygiene.<br>- Precarious living conditions, nutrition difficulties and lack of access to prevention services.<br>- Poor working conditions. |
| **Vulnerable groups** | Minors, unaccompanied minors, disabled and elderly people, pregnant women, single parents with minor children, very young children, disabled persons. | Pregnant women, mothers and babies, children and people at increased risk for infectious disease. |
| **PSYCHO-SOCIAL** | | |
| **Risk factors** | - The fear of human smuggling<br>- Discrimination.<br>- Stressful events at arrival and lack of stability are predictive of psychological problems eight to nine years after arrival<br>- Vulnerability.<br>- Separation from the family, especially from children, can seriously affect a persons' psychological health.<br>- Experiences of discrimination.<br>- Daily hassles of living in refugee camps<br>- Asylum seeking children and adolescents having experienced protracted stays in asylum centres and multiple relocations within the system have been shown to have an increased risk of mental difficulties<br>- The detention period in immigration centres can affect the mental health of some people. | - A long asylum procedure has been correlated with anxiety, depressive and somatoform disorders in adult asylum seekers<br>- Depression caused by the pressure from family back home.<br>- Experiences of discrimination and lack of social integration into the host society are predictive of psychological problems eight to nine years after arrival<br>- Perceived discrimination by the community or the society has been associated with more severe PTSD symptoms<br>- Language and cultural differences.<br>- Vulnerability.<br>- Health adjustment.<br>- Weak network poor social support.<br>- Lack of emotional support<br>- Insecure occupancy.<br>- Poverty. |
| **Vulnerable groups** | - Survivors of torture, rape, other forms of psychological, physical or sexual violence. | |

| **SOCIO-ENVIRONMENTAL HEALTH** | | |
|---|---|---|
| | **Scenario A - Arrival/Transit** | **Scenario B - Asylum seeking/ settling** |
| | - Women and girls traveling alone.<br>- Young refugees, because of their migration history and the living conditions in the host country.<br>Elderly people who arrive alone and people with mental disorders. | |


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# Annex 5

# Guidelines for the development of action plans for implementing a public health response and to strengthen a country's health system in order to address the needs posed by the influx of refugees, asylum seekers and other migrants' (draft)

Co-funded by
the Health Programme
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**SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC**

# GUIDELINES FOR THE DEVELOPMENT OF ACTION PLANS FOR IMPLEMENTING A PUBLIC HEALTH RESPONSE AND TO STRENGTHEN A COUNTRY'S HEALTH SYSTEM IN ORDER TO ADDRESS THE NEEDS POSED BY THE INFLUX OF REFUGEES, ASYLUM SEEKERS AND OTHER MIGRANTS

*Working document*

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## List of acronyms

| | |
|---|---|
| BEOC | Basic emergency obstetric care |
| CD | Communicable disease |
| CEOC | Comprehensive emergency obstetric care |
| EPI | Expanded Programme of Immunization |
| EU | European Union |
| GE | Gastro-enteritis |
| GBV | Gender based violence |
| HIV | Human immunodeficiency virus |
| HRH | Human resources for health |
| IASC | Inter-Agency Standing Committee |
| ICRC | International Committee of the Red Cross |
| IMCI | Integrated management of childhood illnesses |
| MISP | Minimum Initial Service Package |
| MSF | Médecins sans Frontières (Doctors without Borders) |
| MUAC | Mid-upper arm circumference |
| NCD | Non-communicable disease |
| NGO | Non-governmental organization |
| PHC | Primary health care |
| PMTCT | Prevention of mother to child transmission |
| RH | Reproductive health |
| RTI | Respiratory tract infection |
| SGBV | Sexual and gender-based violence |
| SHC | Secondary health care |
| SRH | Sexual and reproductive health |
| STD | Sexually transmitted disease |
| TB | Tuberculosis |
| THC | Tertiary health care |
| UN | United Nations |
| WHO | World Health Organization |
| WP | Work package |

# 1. Introduction

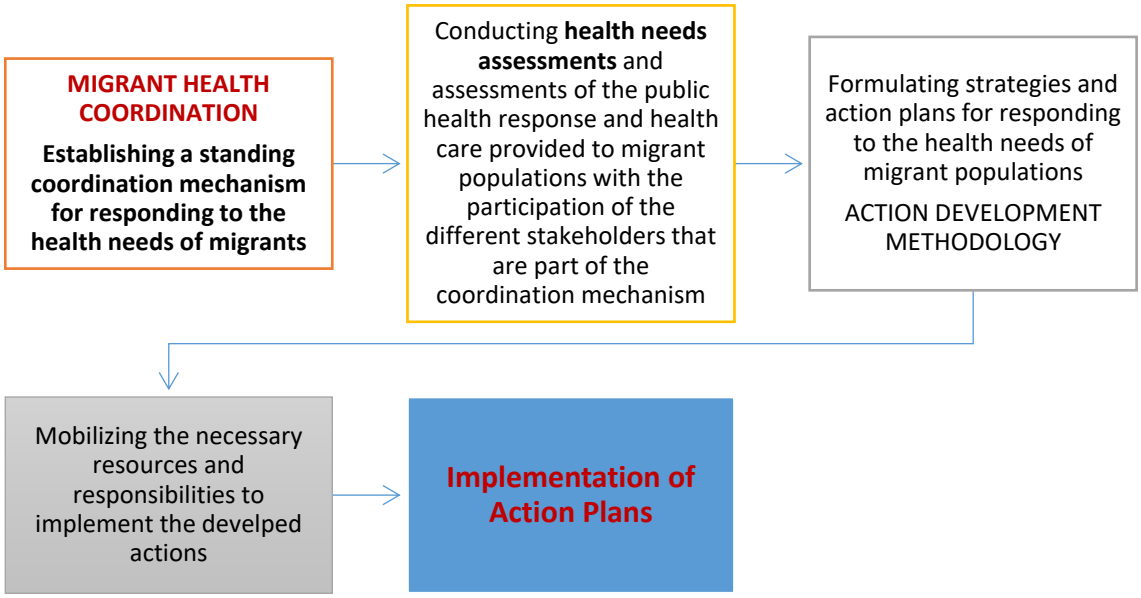
The SH- CAPAC Project was launched by the European Commission on January 1st 2016 to support EU Member States under particular migratory pressure in their response to health related challenges.

SH-CAPAC Project aims at building capacity in areas of coordination practices, needs assessments, planning to strengthen the public health response of local health systems, improving access to health care, and developing health workers' competencies for the delivery of migrant/refugee sensitive health services. One of the project´s expected outcomes is to strengthen EU Member States health systems to address the needs posed by the refugees, asylum seekers and other migrants' influx and support its formulation in at least 8 affected countries.

This Guideline is part of the SH-CAPAC project. Their purpose is to support Member States to develop action plans for implementing a public health response and for reinforcing their health systems in order to respond to the challenges of the refugee, asylum seekers and other migrant's influx.

It has close ties with other frameworks and tools developed as part of the SH- CAPAC project, namely the Health Coordination Framework (WP1) and the Guideline for the assessment of health needs and available health protection resources (WP2). Figure 1 explains how these three tools are connected.

**Figure 1. Public health response implementation roadmap**




Even though the responsibilities in the EU Member States are shared by different ministries, law enforcement agencies and governmental and non-governmental organizations, the driving forces for the public health and health systems response should be the health authorities at different levels. Therefore, they have to be an active player in the country coordination mechanisms at

local, regional and national level from the very beginning. The *Health Coordination Framework* deals with these and other related topics.

Need assessments are essential for coordination, planning and implementation of the health response. Need assessment is a systematic process of collection and analysis of information relevant to the decision makers. This information could come from different sources (literature, data bases, focal groups, field visits and interviews, etc.) and have to be organized, analysed and presented in due form and time to help the decision process. Classically, need assessments identify and prioritize challenges, risks, gaps and unmet health needs. The *assessment guide* (WP-2) helps to identify gaps between health needs and available resources to provide the basis for planning and carrying out action in terms of necessary health provision and preventive measures.

For refugees, asylum seekers and migrants, barriers for accessing health care represent a complex and crucial problem. Newly arriving migrants may face special health risks and, at the same time, they do not receive the care they need because of a constellation of legal, cultural and administrative factors, and also because of the fear of detention. A *Resource Package for ensuring access to health care of refugees, asylum seekers and other migrants in the EU countries* (WP-4) is also part of the SH-CAPAC Project.

## 2. Objectives

The **objective** of this Guideline is to provide to health authorities at national, regional and local levels, and other relevant stakeholders, with tools and ways to develop **action plans** to implement a public health response and strengthening country health systems which are under the pressure of a massive influx of refugees, migrants and asylum seekers, taking into account different situations and scenarios.

This Guideline has been developed having particularly in mind the needs and tasks of health workers at the district level, local health systems, community health centres and local hospitals in government institutions, the Red Cross and other NGO´s health facilities, who are responsible for the provision of health services and the organisation and management of public health interventions.

In such conditions "planning" is not an academic exercise and a "quick and dirty "approach" is usually adopted. Therefore, a simple, understandable and pragmatic approach has been chosen for this Guideline.

On the other hand, continuity with the results of the application of WP-1 and WP-2 Guides needs to be emphasized. Many of the findings of the application of WP-4 framework could also be considered.

## 3. How to use the Guideline

It is recommended that the following points be taken into account when the Guideline is going to be used:

- **Flexibility**: in some EU Member States (or regions) those Action Plans have been developed but this is not the case in others. The Guide has been designed to help in both situations; therefore, any regional or local health authority or manager may decide if the Guideline is going to be used for the elaboration of a new plan or to revise the existing one; more than that, they can select those section that are relevant for their context and customized it to develop or strengthen their response.
- The purpose of **section 4** (*Guiding concepts*) is to facilitate a set of concepts, language and terminology to the Action Plan working team. In many respects, this section summarizes the basic concepts and issues discussed in the Coordination and Assessment guidelines as well in the Resource Package Framework.
- **Section 5** shows how to elaborate Action Plans. This section is in close contact with *Annex 1*: *Elements for developing action plans to implement public health and health services response to migrant´s influx according to type of migrants*. Please, take the content of both, section 4 and Annex as indicative not as compulsory.
- **Section 6** includes *two different scenarios* elaborated from several EU member states country, regional and local experiences at the end of 2015 and the beginning of 2016. Therefore, they need being adjusted accordingly to future context evolution. This section is in close contact with a checklist to facilitate their implementation, and with checklist (Annex 2) that deals with the issue of stockpiling.
- **Section 7** describes some conditions for feasibility and sustainability.
- **Section 8** shows a model for an "Action Plan" document that, again, have to be adapted to particular circumstances and contexts. Action plan template complements this chapter presenting a decision making chart flow that includes the critical points to be considered to deal with massive migrant´s influx.

## 4. Guiding Concepts

A public health and health systems response Action Plan is "*a concise statement of the overall approach to which different partners should contribute with the aim of reducing and avoiding mortality, morbidity and disability among migrants and guaranteeing the access to, and the delivery of, preventive and curative health care as quickly as possible in a sustainable manner*".

In this particular EU influx of migrants, three **main dimensions** have been identified when a public health and health system response action plan is going to be implemented:

- type of country
- type of health problems and risks[1]

[1] Sexual/reproductive health; Sexual and gender-based violence (SGBV); Maternal/child health; Mental health; Non- communicable and chronic illnesses; Communicable diseases and vaccination; Injuries; Socio-Environmental health

- type of migrants[2] and vulnerable groups[3]

Related to **the first dimension,** there are differences among EU Member States both in terms of health laws and policies, organizational and financial arrangements, technical capacities, etc. Additionally, countries are located differently regarding the migratory influx: roughly they may be **arrival**, **in transit** and **destination countries**, even though some countries may be placed in more than one category at the same time.

**Time** is a key factor. First, because migration patterns may vary quickly and some countries may be forced to cope with a heavy migratory pressure from one day to another. And second, because concepts as arrival, transit and destination are not clear cut and they offer a lot of grey zones both from migrants and countries (i.e. depending on circumstances a group of migrants may change of being in transit to be "stranded")

Health problems and organizational arrangements may vary depending on the length of time the migrants will stay in a given place (i.e. from the emergency care to guarantee vital support in the shore lines to the mobile units to treat people in movement, to the primary health surgery in a migrant´s camp, to specialized care needed to treat chronic conditions in a destination city)

Related to **health problems and risks**, a preliminary communication showed that, in 2015, most of health care demand happened during the migrant´s trip. The illness distribution was: respiratory symptoms, trauma, gastrointestinal problems, skin problems and chronic diseases. Malaria was rare and tuberculosis very scarce. Only a small fraction of patients is referred to secondary care, mainly for trauma, respiratory infections, and gynaeco-obstetrics. Most of migrants were men but in the last 2-3 months of 2015 the proportion of women, including pregnant women and old people is increasing.

In addition to this, a series of interviews and focus groups have been conducted in the context of the WP-4 of the SH-CAPAC project in 10 EU countries between February and March 2016[4]. The major findings were:

- Delivery of health care to migrants is seriously hampered by the complexity of **legal and administrative procedures** that have to be executed to guarantee access to care. Care providers are insufficiently familiar with rules that apply for refugees, asylum seekers and migrants, and moreover, some of them act randomly. Some restrictions exist, some

[2] Those categories are: recent arrival, people in transit, asylum seekers, refugee status granted, and undocumented migrants.
[3] Among them: un-accompanied minors, children and adolescents, women, injured people, people with disabilities, and the elderly and un-documented migrants.
[4] The interviews and focus groups were addressed to professionals working in center for refugees and asylum seekers, working in health services where migrants go for health care, "hot spots", arrival camps, transit camps, destination centers, mental health services, and services specialized in health care for victims of sexual violence, mother and child care. They include physicians, nurses, psychologists, intercultural mediators, health and social workers, volunteers for NGO, persons in charge of health services, head of health services, public officers in charge of health issues/refugees affairs at municipal/regional/national levels, and civil servants working with ministries involved in health/justice/immigration.

payments are required for certain services and some treatments and drugs cannot be prescribed.

- **Linguistic and cultural barriers** are systematically identified as one of the major challenges. In many Member States no or insufficient professional interpreters or intercultural mediators are available. Care is often provided on the basis of poor communication and understanding of cultural differences.
- **Lack of health records** hampers the continuity of care. No adequate systems for exchange of medical information between EU Member States exist. It is often impossible to trace patients in movement from one country to another.
- **Living conditions** in the arrival camps has been criticized. In some EU Member States (or regions), hospitals have limited resources to provide pamper, food and clothes to the patients. In countries were a lot of care is provided by NGOs the quality of care may vary.
- **Lack of organization**, abundance of NGOs, lack of knowledge on cultural differences and media pressure have created unjustified **fears among native citizens**, particularly where health resources were limited or underfunded.
- Even though most of migrants do not suffer severe health problems (with the exception of some arrivals to the shorelines), health professionals have to be alert to recognize the few **cases of diseases that are uncommon** in the receiving countries but may be so in the countries of origin.
- The collected information also shows that pregnant women, unaccompanied minors, victims of torture and people with mental post traumatic disorders pose special problems. Due to the factors mentioned above, **mental health care is usually poorly delivered**.

Taking into account both prevalent health problems and risks, and issues related with migrant´s access to health services, a pragmatic, flexible **primary health care approach** is recommended to prepare the Action Plan[5].

## 5. Before starting the Action Plan

The political and institutional circumstances of the current influx of migrants are unusual. There is division of political attitudes and expectations, and institutions like the military and police play a major role in setting the culture of the whole planning and management process. These sorts of considerations need to be thought about **at every stage of the process**, including the selection of the assessment and planning team. That is why we show below some general principles (even though they are fully developed in WP1)

[5] For an updated conceptual approach to this sort of situations see: Bayard Roberts. Health Responses to the humanitarian crisis. Heart (February 2016) http://www.heart-resources.org/wp-content/uploads/2016/03/Bayard-Roberts-Reading-Pack.pdf

**Table 1. Before starting**

1. **Secure commitment from the top.**
   Start the planning process by exploring expectations, clarifying outcomes, and negotiating with the top leadership to secure the commitment and resources that are essential to the planning process.
2. **Involve all the key stakeholders.**
   Negotiate for the participation of all the key stakeholders in the planning process in a politically and culturally sensitive way.
3. **Recognize and manage the effect of the organizational culture**.
   Management of the migrant population involves several types of organizations with very different cultures, for example, the Ministry of Defense, Ministry of Health, NGOs and international organizations. First, recognize which may be the dominant culture in the situation. Second, allow time for the group that is doing the assessments and planning to develop mutual understanding of their different perspectives.
4. **Collect, comprehend and use valid information.**
   The assessments will be based on a mix of objective and subjective information. Because people perceive and understand a situation from their own perspective, it is important to gather information from different sources, e.g. both providers and receivers of care. This also helps reach a consensus in the planning team since they, with their different backgrounds, will tend to trust one source better than another.
5. **Set a clear overall goal.**
   In a situation in which political views and attitudes towards migrant may vary greatly, it is important the stakeholders in the planning team have the opportunity to develop a consensus on expectations and outcomes of the process for the different groups of asylum seekers, refugees and other migrants. They should agree on how the laws and regulations on entitlements are to be interpreted, and what kinds of improvements are possible within these constraints.
6. **Maintain links with operational plans for the health services.**
   Ensure that new plans take into consideration existing priorities of the health services and the possible impact of the new activities proposed by the plan.

Therefore, the **primary health care approach** we recommend to cope with this current influx of migrants should:

- ✓ Be part of a wider, inter-sectoral strategy or plan established to cope with the influx of refugees, asylum seekers and migrants (as settled in the WP-1 *Health Coordination Framework*).
- ✓ Be clearly based on the needs of the refugees, asylum seekers and migrants, the most vulnerable groups and the locations of response (as described in the WP-2 *Assessment Guide*).
- ✓ Consider cross-cutting issues (i.e. human rights and protection, gender, culture, environment -including waste disposal and burial issues, psychosocial support, etc.).

- ✓ Define the priority areas to be addressed during a given period of time, as well as the specific objectives of different actors involved during every period of time.
- ✓ Consider issues related to migrant´s access to health care services (as described in the WP-4 *Resource Package*).
- ✓ Setting the means to measure health response processes and outcomes.
- ✓ Be updated as and when necessary according to new information and/or changes in the situation.

The following questions may be used to check the current situation (baseline) of the response at national, regional and local level, and also the way in which this response adapts to the evolution of the situation.

**Table 2. Check list**

- Are there national and regional/local action plans in the sense it has been defined above? If the **answer is not**, why? And how you could contribute to develop it?

- If the answer is **totally or partially yes**, are these Action Plans:
  - ✓ Part of a wider, inter-sectoral strategy/plan to cope with migrant´s influx?
  - ✓ Adequately supported by the "top" political level?
  - ✓ Involving all the relevant stakeholders?
  - ✓ Recognising the different organizational cultures?
  - ✓ Collecting, comprehending and using valid information?
  - ✓ Setting shared, clear and measurable goals?
  - ✓ Based on the health needs of different categories of migrants, the most vulnerable groups and the locations of response?
  - ✓ Considering adequately cross-cutting issues such as human rights and protection, gender, culture, environment, psycho-social support and other?
  - ✓ Considering adequately issues related to migrant´s access to health care services (including legal and administrative barriers, living conditions, linguistic and cultural issues, medical records, etc.)?
  - ✓ Defining priority areas and specific objectives for the different actors involved?
  - ✓ Including the means to measure health response processes and outcomes.
  - ✓ Being periodically updated accordingly to new information and/or changes in the situation?
  - ✓ Maintaining links with the operational plans for "normal" health services?

In some cases, well prepared **interviews and focal groups** could help both to have a clear picture of the situation (baseline) and to kick off the preparation of an action plan (when there is none), or to improve and/or revise an existing one if it is deemed necessary.

## 6. Preparing the Action Plan

According to the results obtained using the *Health Coordination Guide* and the *Assessment Guide*, as well as the basic issues included in section 5, the team in charge of preparing the Action Plan must:

- Analyse the context, including previous experiences, capacities, resources and constraints[6].
- Define priority areas, location of response, health problems, vulnerable sub-groups and potential health risks[7].
- Define objectives that are SMART: **s**pecific, **m**easurable, **a**greed upon, **r**ealistic and **t**ime-based.
- Analyse the living conditions of hotspots, detention centres and camps, etc. and propose measures to improve them when needed.
- Ensure that life-threatening needs (i.e. security, food, shelter, water&sanitation, acute medical emergencies) of migrants are met.
- Take into account seasonal variations and the expected evolution of the migrant´s influx.
- Select strategies that are appropriate and feasible in the local/regional context and prioritize them. In this stage the political, institutional and technical aspects need to be considered together. Prioritization is always a tricky process. It involves exercising judgment and them trying to align the "judgements" of all stakeholders involved.
- Define well the sequence of activities, using diagrams or specific methodologies if deem appropriate (i.e. PERT, GANTT).
- Adjust the resources (material, human, financial) for each activity, decide on what can be fit into the budget, and work for them to be available.
- Focus on filling the gaps in areas where large number of migrants are concentrated both in critical life-sustaining services and in information that is critical for determining needs and planning.
- Guarantee reliable and rapid means of communication among different providers.
- Try to make sure each health organization taking responsibility for a particular area or activity has, or will soon have, the capacity required.
- While doing this, estimate how many migrants will probably be attended in a medium-long term period by local and regional health system and the better ways to cope with it.

When conflicting perspectives and pressures arise, it would be wise to adopt and *incremental approach* and proceed gradually, trying to get consensus on intermediate objectives, achieving them and, and then moving to a higher objective as soon the context is favourable.

Another important point is to avoid short-term actions that could create problems in the medium and long-term "normal" service delivery. In particular, it is important to avoid consolidating

[6] Please see the Health Coordination Guide from WP1
[7] Please see the Guide for assessment of health needs and available health protection resources from WP2

"specific health systems for migrants" that could hamper their integration in the EU Member State "regular" health system.

Preparing and disseminating **clinical guidelines** could facilitate the work, particularly to field units. They have to deal with the most prevalent conditions among the migrants´ population and vulnerable groups (i.e. advanced vital support, pregnant women, child and maternal health, vaccination, nutrition, injuries and trauma, sexual and reproductive health, psychological support, mental issues, people with disabilities, systematic control of some communicable and non-communicable diseases, and other).

These clinical guidelines could be part of the Action Plan or the Plan may mandate their elaboration.

They may include both criteria for primary care and the thresholds at which the people in charge should make the alerts and/or take specified actions as well as clear procedures for the referral of cases.

Even though these clinical guidelines may be written taking into account the particular circumstances in which such clinical conditions are detected and treated (i.e. shorelines, hotspots, refugee camps, mobile units), **the basic assumption is that the quality of care must be appropriate; that means with the same quality standards that for the EU Member State citizens.**

The following questions may be used to orient the preparation of the Action Plan at the national, regional and local level.

**Table 3. Criteria to prepare an Action Plan**

Is there any Action Plan that has been developed after a situation assessment that includes analysis of the context, previous experiences, capacities, resources and constraints? If the **answer is not**, what are the reasons, explanations, barriers? How could you contribute to overcome them?

If the **answer is yes**, check the if the Action Plan meets to the following criteria:

- Does it include priority areas, location of response, health problems, vulnerable sub-groups and potential risks?
- Are the objectives SMART (i.e. specific, measurable, agreed upon, realistic and time-based)
- Ensure that life-threatening needs (i.e. security, food, shelter, water & sanitation, acute medical emergencies) are met?
- Has been taken into account seasonal variations and the expected evolution of the situation?
- Has been selected strategies that are agreed upon and they are appropriate and feasible in the local/regional context?

- Is there a focus on filling the gaps in areas where large number of migrants are concentrated both in critical life-sustaining services and in information that is critical for determining needs and planning?
- Are the activities well defined and sequenced?
- Are the resources (material, human, financial) for each activity well allocated and available?
- Are there reliable and rapid means of communication and transport among different providers?
- The Action Plan includes or mandate elaborating clinical guidelines for the most prevalent conditions among migrants with appropriate standards of quality?
- Each organization taking responsibility for a particular area or activity has, or will soon have, the capacity required?

Additionally, **Annex 1** shows the different health responses and the minimum health services to be ensured, the basic equipment/supplies/resources to be provided, the necessary network/coordination tasks and different notes to remember per type of migrant according to the phase in their migration trajectory. It ranges from what should be foreseen in case of recent arrivals (including in hotspots), in different reception facilities for people in transit, in different reception facilities for asylum seekers and then finally for refugees integrating them in the general public health system. For each of these migrant groups we specify what is to be taken into account in the case of undocumented migrants.

## 7. Scenarios for countries formulating action plans

Elaborating **scenarios** and **contingency plans** according to them may be useful. There are good references that can be read on this topic, some of them elaborated in the light of previous humanitarian crisis.

A pragmatic public health response to this crisis may use two possible scenarios. These scenarios are based on two fundamental factors: time and number of migrants.

The two scenarios are:

- Scenario A: a time period in which migrants come in to a country during **hours or days**. The total number of migrants is seriously large sized and overcome receiving capacities of the country. A contingency plan for public health threats and activation of all available resources is prepared and taken in to account.

- Scenario B: a time period in which migrants come in to a country during **weeks** or **months**. The total numbers of migrants might be relatively big, but the influx is continual and it is distributed in a relatively long lasted time period. So that health services can be modified accordingly to the migrants' needs and a sensitive primary health care services approach.

### a. Scenario A

The **Scenario A** should be seen on one hand, as a description of current situation in the "buffer" countries and, on the other hand, as a possible role model for crisis management and planning schemes for other countries.

The basic features of this scenario are tremendous number of people located in the one place at the same time. The response, including health response, demands all resources available.

The scenario could last a few hours or days or weeks (even months) depending on international relations, security measures, local conditions etc. Uncertainty is obviously an issue.

How might this scenario be coping with? There is no simple or comprehensive response. Local factors and conditions are determinant. These local factors and conditions have to be taking into account and each action plan needs to be tailored for those limitations.

What lessons have been learned so far? Here you may find some:

- **Migration patterns may vary quickly** and some countries may be under a heavy migratory pressure from one day to the other. There are so many variables and factors operating that changes cannot be predicted. Unpredictable variables may strike and change current stage, consequently it is impossible to prepare a plan for all possible situations that may occur. We must accept the resources are always limited and moving them is a way to maximize. Therefore, **day by day assessment, flexibility and adaptability** are essential.

- So far, **countries responses vary a lot**. Elaborating contingency plans, foster coordination mechanisms among different stakeholders, and establishing ad hoc, integrated, top-down schemes are different models. In all of them, good coordination between health authorities and NGO´s is essential. A country mentioned how ICRC is acting as an "umbrella" to facilitate the coordination between the government and other NGO´s.

- Give priority to **communication and coordination** (including at the international level) among decision makers, NGO´s and other players involved in the planning process and should have been responsible for execution of the plans and practical measures. **Rebalance health issues and security** issues: health issues use to be underestimated at the field level.

- Stockpiling of appropriate drugs, vaccines and other medical supplies and general supplies like babies' food, quilts, shelters, water supplies, sanitation etc. Although, the planning process may incorporate adequate amount of medical supplies, the **supplies cannot track the transiting groups of migrants from one country to another**. International laws cannot allow import, export or transfer of medical drugs, vaccines and supplies among countries - at least at the required speed. Countries might **take advantage of WHO and other international institutions experience** and criteria on this. Be aware of problems related to European legislation and vaccines. A simple checklist for dealing with the

stockpiling of more common supplies is presented below. Please, adapt it to your particular circumstances.

Checklist for stockpiles

| No. | Are you able to provide General Stockpiles? | Yes | No | If answer no, why? How could you contribute to solve this? |
|---|---|---|---|---|
| | Drugs/ treatment | | | |
| | Water pipe | | | |
| | Clothing | | | |
| | Accommodation | | | |
| | Ensuring warmth | | | |
| | Waste removal | | | |
| **No.** | **Are you able to provide Specific Stockpiles for…?** | **Yes** | **No** | **If answer no, why? How could you contribute to solve this?** |
| | Small surgery/wound | | | |
| | Minors | | | |
| | Pregnant women | | | |
| | Others (high virulence, non-communicable diseases, etc.) | | | |

- The best-prepared plan is an unrealistic sheet of paper without adequate **human resources**. Health personnel in charge of providing this sort of care must be sufficient and trained. Health care authorities and providers have to listen them in order to assure the appropriateness of care. Specific clinical guidelines for them –including health and human rights, and legal and administrative issues- have to be elaborated and disseminated. Their special efforts need to be recognized and their security guaranteed.

- It is important to wider the public health response strategies on basic aspects of the **environment**. Poor environmental conditions, insufficient access to drinking water and sanitation aggravate health status of the migrants and might pose potential health risk for inland community as well. This is particularly important where big camps with hundreds or thousands of people are located.

- **Personal identification** enabling to tag specific medical information to the right person and, eventually, to share this information among health institutions in different countries is important. In spite of the fact that technologies for this identification system are available, there are difficulties to implement them, in part due to the fact that many migrants reject them for legal and security considerations.

- Given their experience and means, **the military** could be very useful (and they are being used in some countries) particularly for logistic and communication purposes. For obvious reasons, they might work unarmed and been kept **in a "second" line**.

Three **check-lists** that can be used **to help to and monitor** the preparation of the Action Plans for this scenario -or to revise an existing one- are presented below:

**Checklists: SCENARIO A**

**1. Some questions to be answered before a refugee´s camp is set up (The Reconnaissance Stage)**

| **Stage 1** | **The Reconnaissance of a Possible Location** | | | |
|---|---|---|---|---|
| **No.** | **Question** | **Yes** | **No** | **If answer no, why? How could you contribute to solve this?** |
| • | Has the selected area or location appropriate size for installation of all important staff and issues?<br>(Think mainly on people, staff, stockpiles, corridors and infrastructure, vehicles place for quarantine, mortuary services, savage water and waste management) | | | |
| • | Do we set effective checkpoints and control movement of the people in the selected area?<br>(Think about security measures and emergency evacuation in case of fire or violence) | | | |
| • | Is selected are located pretty close to cities or places with high population density?<br>(Think about possible spread of communicable diseases, security measures and specific hazards) | | | |
| • | Is evacuation and transport of people possible besides main transport corridors in a case of emergency?<br>(Think about possible collisions and traffic jams or safety measures) | | | |
| • | Are climatic and environmental conditions take in to account in the selected area?<br>(Think about wind directions and health risk in a case of fire or emission of chemical substances or biological agents in to the air; eventuality that trash will be burnt to the ground; use health risk assessment and risk anticipation) | | | |
| • | Are sources of potable water utilized for huge amount of inlands located on the selected area?<br>(Precautionary principles against diseases spreading and protection of water resources; think on all drinking water resources as groundwater, springs, aquifers or surface water | | | |

| | | | | |
|---|---|---|---|---|
| | and for mineral springs or locations which can be protected because of water cycle) | | | |
| • | Can we do pest control in the selected area?<br>(Think about insects, small rodents and other animals can be fed by biological waste and food supplies) | | | |
| • | Can we use the place for temporary burry of departed in the case of high contagious infectious?<br>(Although, the probability is relatively low, think about the eventuality that high contagious diseases may occur) | | | |
| • | Can we restore the environment in the selected area when the camp will be terminated?<br>(Think about environmental damages that may happen and potential environmental health risk for inlands) | | | |

**2. Some questions to be answered before the camp is built-up (The Building-Up Stage)**

| **Stage 2** | **The Building-Up** | | | |
|---|---|---|---|---|
| **No.** | **Question** | **Yes** | **No** | **If answer no, why? How could you contribute to solve this?** |
| • | Is the each sector of the camp clearly tagged?<br>(Think about every single sector of the camp and its single purpose; avoid that vehicle corridors cross corridors for people, high risk activities (e.g. first aid station) are separated from others activities or sectors (e.g. food processing) | | | |
| • | Are the evacuation corridors set?<br>(Think about an evacuation in a case of emergency, fire etc.) | | | |
| • | Is there enough space for staff and its changing rooms?<br>(Think about the staff, its duty and safety precautions at work) | | | |
| • | Is there a space for health entry and exit screening procedures?<br>(Think about health check not only for migrants, but for staff too) | | | |
| • | Is there enough space for first aid and emergency care? | | | |
| • | Is there enough space for stockpiles? | | | |
| • | Are the procedure and waste management rules set?<br>(Think about all possible type of waste and its possible health risks; especially biologically contaminated medical waste) | | | |
| • | Is the space for quarantine big enough? | | | |

| | | | | |
|---|---|---|---|---|
| | (Think about spreading of common contagious diseases; in the case of emergency quarantine can be ordered for staff too) | | | |
| • | Is the space for waste disposal set? | | | |

### 3. Some questions to be answered about how the camp will operate (The Operational Stage)

| **Stage 3** | **The Operational Stage** | | | |
|---|---|---|---|---|
| **No.** | **Question** | **Yes** | **No** | **If answer no, why? How could you contribute to solve this?** |
| • | Is the each sector of the camp clearly tagged? (Different colours may be used) | | | |
| • | Are the corridors clearly tagged? | | | |
| • | Are the public health measures set? | | | |
| • | Are the public health measures obeyed? | | | |
| • | Are the public health measures supervised? | | | |
| • | Are the emergency care and clinical guidelines set? | | | |
| • | Are the emergency care and clinical guidelines obeyed? | | | |
| • | Are the emergency care and clinical guidelines supervised? | | | |
| • | Are the precautionary measures set? | | | |
| • | Are the precautionary measures obeyed? | | | |
| • | Are the precautionary measures supervised? | | | |
| • | Are the evacuation measures set? And obeyed? | | | |
| • | Are the evacuation measures obeyed? | | | |
| • | Are the evacuations routes kept clear? | | | |
| • | Are the security measures set? | | | |
| • | Are the security measures obeyed? | | | |
| • | Are the security measures supervised? | | | |
| • | Are the security standards for third party (mainly NGOs staff etc.) set? | | | |
| • | Does third party obey the security standards? | | | |
| • | Are the controls measures set and executed? | | | |
| • | Is the chain of command strictly set? | | | |
| • | Are the communication and coordination rules set? | | | |
| • | Are the communication routes and schemes verified and updated in periodical time? | | | |
| • | Are the responsibilities and competencies strictly set? | | | |

| | | | | |
|---|---|---|---|---|
| • | Are the stockpiles schemes set and updated? | | | |
| • | Are the stockpiles regularly renewed? | | | |

### b. Scenario B

The **Scenario B** is pretty close to regular situation it used to be in Europe before the current migration crisis.

The most significant role in public health response is providing of adequate primary health care services for all migrants.

Health personnel have to be trained and educated and health services should be enriched by migrants' sensitive approach, including interpretation and cultural mediation.

The health care services should be ready to provide all spectrums of health care from emergency care, primary health care, mother and child care and adequate response for those who suffer from chronic diseases.

Relatively limited numbers of migrants who are spread in a relatively long time give health services professionals and managers an opportunity to prepare specific models for health care provisions, model for financial sustainability and close cooperation with non- governmental organization and state agencies.

The situation is almost similar to regular conditions and organization of health services may be equal as for inlands. The scenario gives more time and space for implementing health needs oriented services.

A **check list** that can be used **to help to and monitor** the preparation of the Action Plan for this scenario –or to revise an existing one - is presented below.

**Checklist: SCENARIO B**

| **Stage 1** | **Strategies related to the health care oriented towards cultural and ethnic diversity** | | | |
|---|---|---|---|---|
| **No.** | **Question** | **Yes** | **No** | **If answer no, why? How could you contribute to solve this?** |
| | Do you think are there any strategies related to health care oriented towards cultural and ethnic diversity in your own country / regional context? | | | |
| | What advantages and limitations can you identify in culture- ethnic-specific health | | | |

| | | | | |
|---|---|---|---|---|
| | care services, in self-organized health care services or in health care services oriented towards cultural and ethnic diversity and reduction of health inequalities? | | | |
| | Do you think it could be useful to work with a mixed model? | | | |
| **Stage 2** | **Strategies for planning and implementing actions related to health care with migrants and ethnic minorities** | | | |
| **No.** | **Question** | **Yes** | **No** | **If answer no, why? How could you contribute to solve this?** |
| | Could you list reasons for taking cultural diversity into account in your own institutional context? | | | |
| | Could you identify relevant stakeholders? | | | |
| | Could you list potential barriers for the implementation of management changes? | | | |
| | Could you introduce a service organization oriented towards cultural and ethnic diversity in your institution? | | | |
| **Stage 3** | **Strategies and good practices related to health promotion and prevention** | | | |
| **No.** | **Question** | **Yes** | **No** | **If answer no, why? How could you contribute to solve this?** |
| | Could you identify any strategies, or good practices related to health promotion in your national context? | | | |
| | Could you identify relevant health promotion stakeholders? | | | |
| | Could you reflect on conflict situations in health prevention and health promotion interventions oriented towards cultural and ethnic diversity, and strategies to resolve the situation? | | | |

In both scenarios, a good **communication strategy** of migrant´s health care arrangements, including potential health risks to the country citizens, is required. Citizens´ perception about these issues, accurate or not, is a critical issue. Therefore, a good communication strategy should be established, including the choosing of credible speakers to communicate it.

Additionally, **contingency plans** to cope with **worst case** scenarios (i.e. new and unexpected massive migrant influx; overcrowding of locations; deterioration of security conditions, secondary disasters like floods, earthquakes, etc.; outbreaks; breakdown of in-country supplies chains, etc.) are also recommendable.

## 8. Contingency Plans

A contingency plan is a tool to anticipate and solve problems that typically arise during a situation of crisis that requires a rapid and coordinated response. Experience confirms that effectiveness of the response is heavily influenced by the level of **preparedness** and **planning** of responding agencies/organizations, as well as the capacities and resources available to them.

The fundamental reason for contingency planning is **to improve the quality of the response.** Planning in advance of an emergency allows participants time to think through and address some critical questions including:

- What could happen? When?
- What would be the impact on the country, region affected?
- What actions would be required to meet the expected needs?
- How would agencies/organizations work together?
- What resources would be required?
- What can agencies/organizations do to be better prepared?

Contingency planning provides an opportunity to identify constraints and focus on operational issues prior to the on-set of a crisis. For example, it provides opportunities to map the strengths and weakness of a migrant´s rescue system, potential areas of rights violations, assess logistical infrastructure such as port or housing capacity, and assess coordination and institutional capacity.

There are some guidelines for contingency planning elaborated for the humanitarian assistance (i.e. *Interagency contingency planning guidelines for humanitarian assistance*) that could be helpful. Typically they establish four phases of the contingency planning process:

- **Preparation**: political commitment, establish a steering group of senior decision-makers, establish a technical level, contingency planning working group, structure the process and ensure adequate facilitation and take stock of previous experiences are the key elements of the first phase.
- **Analysis**: hazard and risk analysis, scenarios building and defining planning assumptions (including projections of needs and assessing of potential constraints) are the key elements of the second phase.
- **Response Planning**: agree upon response objectives and strategies, define management and coordination arrangements, define collective and individual actions to meet with the objectives and prioritize them are key elements of this phase.
- **Implementing preparedness**: defining and monitoring early warning events that could trigger the activation the contingency plan and the actions to be taken in the first hours or days, as well as the ways and procedures to update the contingency plan are key elements of this phase.

When you are preparing a contingency plan, it is important to avoid the "**consolidation trap**", when a large planning document is compiled with the inputs from multiple sectors/clusters and agencies/organizations. The result is a complex and dense document that is difficult to develop, update and use. This trap can be avoided by defining what documents will be useful and what is usefully consolidated. Most often this means a set of different documents at inter-agency, sector/cluster and organizational level. For example, detailed sector/cluster contingency plans are not useful for senior decision makers -or donors- who need short focused documents that highlight the potential scenarios, response strategies, and resource needs. By contrast, health facilities or hot-spot managers definitely need the details.

It could be wise to prepare the contingency plan following a "What- if" or "If - then" logic. Particularly in order to identify which parts of the plan –or which assumptions that it depends upon- are most at **risk of failure** and setting the best alternatives to cope with them.

## 9. Feasibility and sustainability

In general, feasibility and sustainability may not seem so relevant for the short-term but they are important for strengthening the country's health system at the same time it has to deal with migrant´s health needs.

There are some aspects where an appropriate management of the crisis could help fostering the common health system:

- Future disaster preparedness and relief operations.
- Communication and coordination among different stakeholders and levels.
- Health information systems, both for health risks and needs and for health facilities management.
- Mobile health facilities and transport.
- Purchasing and stockpiling.
- Modalities and partners for contracting out health services
- Promote the essential drug concept and medical standardized protocols.
- Legal and normative issues, particularly those related with the entitlement of migrants to be covered by EU Member States public health systems and services in the medium and long run.
- Capacity for dealing with the cultural & ethnic diversity.

The transit between the "crisis" situation and the "normal" situation is not easy. In the past some "acute crisis" have evolved towards a sort of "protracted crisis". This implies that arrangements made for days or weeks may last for months or even years. The evolution of this particular crisis is difficult to predict. Realistic financial estimates are therefore required for both the short term and the subsequent "normal" situation, as well as the assessment of material resources and personal capacities.

## 10. Model for an Action Plan Structure

A model for an action plan structure is presented below[8]. This structure is purely indicative. Users must feel free for adapting it to their particular circumstances and context.

**Table 4. Action Plan structure**

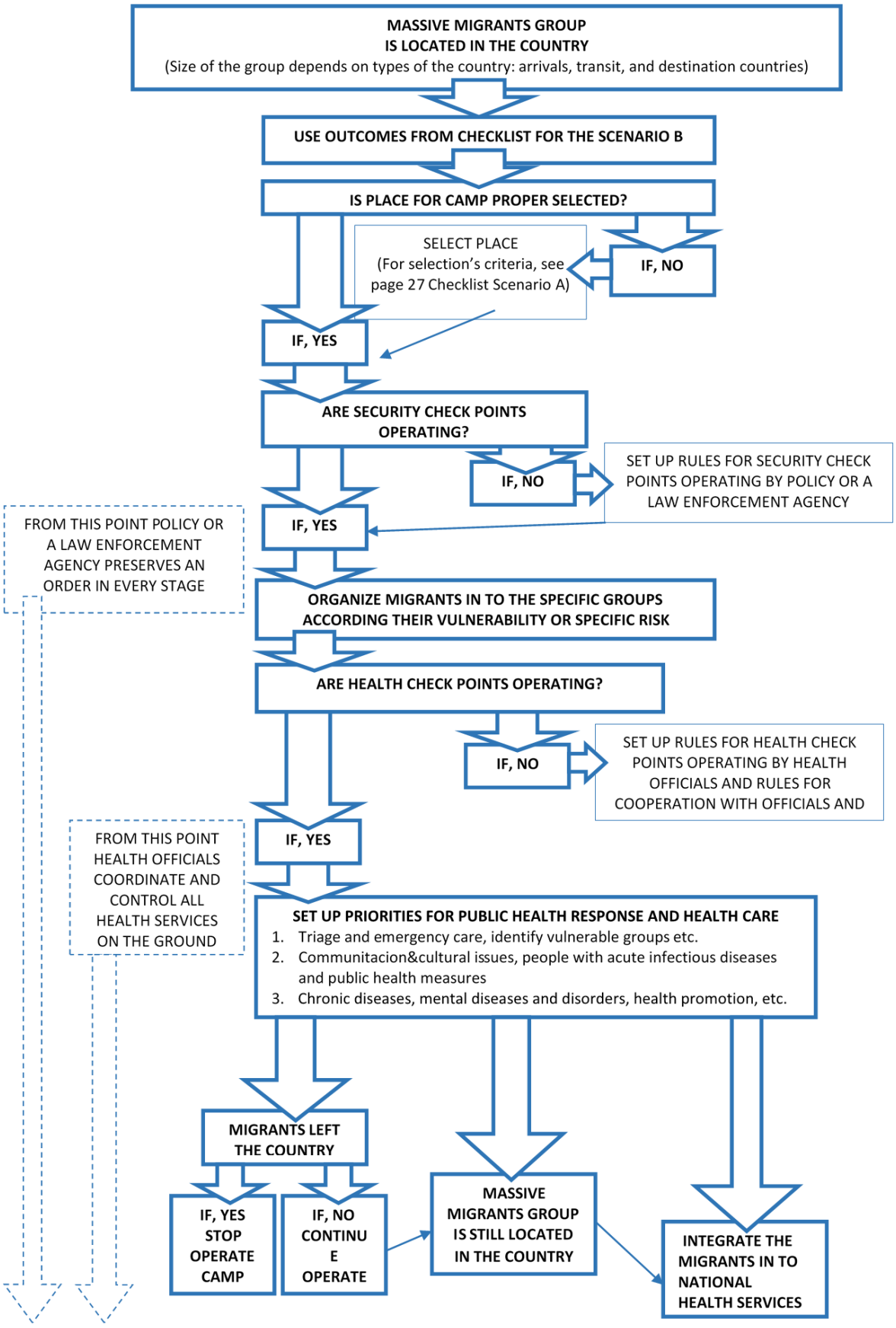
| | |
|---|---|
| **1. Executive summary** (max. 1 page) | • The crisis<br>• Priority needs and response plan<br>• Amount of money needed<br>• Time span covered by this action plan (cannot be longer than 6 months) |
| **2. Context and consequences** (max.1,5 page) | *Context*<br>• Preliminary scenario definition<br>• What happened? Where?<br>• Pre-influx situation and baseline data (i.e. public health situation and health services strengthen and weaknesses, human resources and health financing, etc.)<br>• What has happened since the influx began? (e.g. information gathered, assessments done, government request, international response)<br>*Consequences*<br>• Who is most affected?<br>• What are the needs as a direct and immediate result of this crisis?<br>• What are the priority sectors for response? (Choices in terms of shelter and other non-food items, water and sanitation, food, information, coordination and support services, etc.).<br>• What would the consequences in the medium-long term be depending on the ways the response is organized? |
| **3. Response plan** (max. 2 pages) | • Sectoral needs analysis resume.<br>• Objectives (No more than three, each of which is specific and measurable)<br>• Expected outcomes and impact.<br>• Proposed public health and health services delivery activities which can be implemented within time span of this strategy/appeal (maximum 6 months) include details of project, objectives, beneficiaries, partners, budget, expected outcomes and impact. |
| **4. Roles and responsibilities** | • Detail how the response is being coordinated and who is responsible within the government and other major stakeholders.<br>• Health sector lead, key partners and contact information. |

[8] Adapted from: Pacific Humanitariam Team. Emergency Preapredness&Emergency and response Plan. Annex 5. Action Plan Template

<table>
<tr><td>(1/2 page)</td><td><ul><li>Table indicating the major humanitarian stakeholders (government, UN, Red Cross, NGOs) that are responding to the crisis in affected regions.</li></ul></td></tr>
<tr><td>5. Sketch tables</td><td>For each particular project (i.e. fostering health facilities at the ground, training health personnel, stockpiling medicines and other supplies) complete the following table. Be concise and brief.<br><br>
<table>
<tr><td>Name of responsible</td><td></td></tr>
<tr><td>Project title</td><td></td></tr>
<tr><td>Activity reference</td><td></td></tr>
<tr><td>Description</td><td></td></tr>
<tr><td>Objective(s)</td><td></td></tr>
<tr><td>Beneficiaries</td><td>Total:<br>Women<br>Children</td></tr>
<tr><td>Partners (if needed)</td><td></td></tr>
<tr><td>Budget</td><td>Requirements:<br>Funded<br>Unmet</td></tr>
<tr><td>Expected outputs/impacts</td><td></td></tr>
</table></td></tr>
<tr><td>6. Annexes</td><td>Include all relevant annexes, for example, the summary of activities and funding requirements and the summary of international assistance, if it is the case.</td></tr>
</table>

**The Action Plan template for massive migrant´s influx** (see below) presents a decision making chart flow trying to summarize the complex interactions originated by a massive migrant´s influx and when you may use some of the chapters and annexes of this framework.

**Figure 3. Action plan template**



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# 12. Annexes

## ANNEX 1. Elements for developing action plans to implement public health and health services response to migrant´s influx according to type of migrants

**Recent Arrivals (Including Hotspots)**

| Health response | Minimum health services to be ensured | Basic equipment/supplies/ resources to be provided | Network/coordination tasks | ! Remember |
|---|---|---|---|---|
| Triage/Assessment<br>Acute care | • First aid:<br>  • Resuscitation/emergency care aiming at stabilizing and refer if necessary/<br>  • 24/7 Referral System for obstetric & newborn emergencies established<br>  • Health assessment re identification of pregnant women, elderly, disabilities, special needs including CD, NCD and RH<br>• Psychological first aid: Prepare, Look, Listen, Link<br>• SGBV prevention and response | • Transport 24/7<br>• Communication/interpretation, appropriate materials<br>• Appropriate health registration<br>• Staff: female human resources in health<br>• Supplies:<br>  • MISP<br>  • Individual delivery kits (plastic bag, toilet soap, plastic draw sheet, razor blade, tape, cotton towels, gloves, pictorial instruction sheet) provided to visibly pregnant women & girls<br>  • Contraceptives available to meet demand<br>  • Post rape treatment kit: levonorgestrel, antibiotics (azithromycin, cefixime,…), Lamivudine/Zidovudine, pregnancy test, bag, guidelines and checklists<br>  • Suture of tears/vaginal examination kit: chlorhexidine, polyvidone iodine, lubricant, sutures, compress, gloves, Mayo scissors, needle holder, retractor, speculum, forceps, tray<br>• Security personnel | • Coordination at local level with all partners involved preferably under local health authority's responsibility<br>• Hotspot or reception facility aware of referral services | • Avoid separation of families at registration<br>• Consider photographs (smartphone) of children<br>• Adapted communication skills and materials (language, same-sex interviewers, pictograms, drawings,…)<br>• Don't use registration procedures which rely only on household registration, as they exclude some from accessing resources, in turn increasing their risk of exploitation and abuse<br>• Psychological first aid process = PLLL:<br>  • **Prepare:** inform yourself quickly about the crisis event, available services and supports, safety and security concerns<br>  • **Look:** Check for safety and shelter, go first to people with obvious urgent basic needs and those with serious distress reactions |

| | | | | |
|---|---|---|---|---|
| | | • Secure and confidential environment<br>• Legal protection and advice<br>• Staff trained in psychological first aid<br>• SGBV staff<br>• IASC guidelines | | • **Listen:** approach people who may need support, ask about their needs and concerns, listen and help them to feel calm (again)<br>• **Link:** help people to address basic needs and access services, to cope with problems, give information and connect them with loved ones and social support |
| ***Unaccompanied minors*** | • Medical First aid<br>• Resuscitation/emergency care aiming at stabilizing and refer if necessary (Assess potential consequences of lengthy and unsafe travel)<br>• RH needs, disability<br>• Psychosocial first aid: prepare, look, listen, link<br>• SGBV prevention and response | • Transport 24/7<br>• Communication/interpretation, appropriate materials<br>• Appropriate health registration<br>• Staff: female human resources in health<br>• Supplies:<br>  • MISP<br>  • Individual Delivery Kits provided to visibly pregnant women & girls<br>  • Contraceptives available to meet demand<br>  • Security personnel<br>  • Secure and confidential environment<br>  • Legal protection and advice<br>  • staff trained in psychological first aid<br>  • SGBV staff<br>  • IASC guidelines<br>  • Senperforto Framework SGBV prevention & response | | • Avoid separation of families<br>• Consider photographs (smartphone) of children<br>• Psychological first aid process=PLLL |

**People in Transit: Reception Facilities (from a few hours to months)**

| Health response | Minimum health services to be ensured | Basic equipment/supplies/ resources to be provided | Network/coordination tasks | ! Remember |
|---|---|---|---|---|
| Comprehensive PHC and 24/7 Referral System when necessary | • General Outpatient services (NCD mainly cardiovascular diseases including hypertension, and diabetes, RTI…)<br>• Psychological first aid in first hours: prepare, look, listen, link.<br>• Days after: Follow up on trauma care,<br>• Referral to SHC if necessary 24/7<br>• PMTCT in place<br>• SGBV prevention and response | • Transport (ambulance 24/7)<br>• Communication/interpretation<br>• Staff : Female HRH including staff trained in BEOC<br>• Basic supplies/equipment including:<br>  • Vaccines/ cold chain<br>  • Individual delivery kits: plastic bag, toilet soap, plastic draw sheet, razor blade, tape, cotton towels, gloves, pictorial instruction sheet<br>  • Post rape treatment kit: levonorgestrel, antibiotics (azithromycin, cefixime,…), Lamivudine/Zidovudine, pregnancy test, bag, guidelines and checklists<br>  • Suture of tears/vaginal examination kit: chlorhexidine, polyvidone iodine, lubricant, sutures, compress, gloves, Mayo scissors, needle holder, retractor, speculum, forceps, tray<br>• Culturally sensitive materials on STI & HIV prevention<br>• Senperforto Framework SGBV prevention & response | • With Local hospital for referrals: X-ray, lab, blood bank surgery and BEOC/CEOC<br>• Coordinated response with partners with specific technical resources re SGBV, HIV, Psychosocial support, disabilities<br>• Local health workers<br>• Security personnel | • No Overcrowding (transmission of specific communicable diseases like TB, GE, meningococcal meningitis, scabies…)<br>• Ensure water and sanitation (prevention of GE,<br>• Ensure appropriate separate sanitation and<br>• Ensure privacy for consultations<br>• Teach and support (exclusive) breast feeding practices, discourage infant formula feeding if possible in the first half year<br>• Ensure sleeping areas for women and girls and appropriate lighting and locks from inside<br>• Security patrols in displacement sites<br>• Highlight suspect features as unexplained bruising, fractures, trouble walking or sitting, excessive emotions, extremes in behaviour, attachment troubles, STI or pregnancy in young children<br>• Reduce or eliminate fees for GBV-related services and public health related intervention |

| | | | | |
|---|---|---|---|---|
| ***Unaccompanied minors*** | • Child health: can be integrated in outpatient clinic<br>  • Expanded Programme of Immunization (EPI)<br>  • Nutrition<br>  • Integrated management of childhood illnesses (IMCI)<br>• Referral to SHC if necessary<br>• Trace victims of SGBV | • Transport (ambulance): 24/7<br>• Communication. Interpretation<br>• Basic supplies/equipment<br>  • Vaccines/ cold chain<br>  • MUAC and fortified supplements<br>  • Protocols<br>• Consider Mobile clinic for specialist referral<br>• Culturally sensitive materials on STI & HIV prevention<br>• Temporary separate housing for unaccompanied children until a foster care situation can be arranged | • Coordinate with Local hospital with X ray, lab, surgical unit, blood bank access,<br>• Coordinate with partners involved in child care and protection | IDEM<br>• Child friendly area<br>• Only use valid documented proof of immunization. In the absence of proof, vaccinate accordingly using PMR for follow up and avoidance of unnecessary repeats.<br>• Highlight suspect features as unexplained bruising, fractures, trouble walking or sitting, excessive emotions, extremes in behaviour, attachment troubles, STI or pregnancy in young children<br>• Identify the Signs of Child (Sexual) Abuse based on age-specific symptoms |
| | • Psychosocial support | • Trained staff | • Coordinate with partners who have competencies and skills | |
| | • Communicable diseases:<br>• Surveillance of TB, HIV, STI other relevant diseases (hepatitis, GE outbreaks, Scabies, vaccine preventable diseases)<br>• Consider syndromic surveillance. | • Consider rapid test kits depending on the main countries of origin (i.e. malaria)<br>• Treatment supplies for known HIV cases<br>• Careful follow up of known TB cases to ensure continuity of care and avoidance of multi drug resistance | • Surveillance network across countries (important for known TB cases) | • Avoid mandatory testing.<br>• TB and HIV testing not a priority in acute setting. TB care and control not to be implemented if movement expected in the near future<br>• Any screening should be connected to a process of diagnosis and treatment |

| | | | | |
|---|---|---|---|---|
| | • Take into consideration country of origin (i.e. malaria, polio, cholera) | | | |
| ***Unaccompanied minors*** | • Outpatient services<br>• RH, psycho social support, special needs (disability)<br>• SGBV prevention and response | • Trained staff<br>• Senperforto Framework SGBV prevention & response | • Coordination with Partners with pre requisite skills | • Avoid mandatory testing.<br>• See chapter 1 above |

**Asylum Seekers: Need to integrate migrants in the regular health system (link to national health plan)**

| Health response | Minimum health services to be ensured | Basic equipment/supplies/ resources to be provided | Network/coordination tasks | ! Remember |
|---|---|---|---|---|
| Comprehensive PHC, SHC and THC and rehabilitative services | • Follow up of known illnesses (CD and NCD)<br>• Ensure start of treatment of newly diagnosed TB cases<br>• Health promotion and prevention<br>• Psychosocial support<br>• SRH<br>• SGBV prevention and response | • Female HRH<br>• Trained staff in health entitlements of migrants and cultural sensitivities<br>• Interpreter facility<br>• Health promotion materials in most prevalent languages<br>• Senperforto Framework SGBV prevention & response: code of conduct, sensitisation, standard operating procedure, training | • NHA, RHA<br>• Specialised psychosocial services<br>• NGOs and volunteer organization<br>• TB surveillance coordination<br>• Social protection<br>• Link with SGBV actors<br>• Education (school health) | • Ensure migrant awareness and understanding of health entitlements |
| ***Unaccompanied minors*** | • Psychosocial support<br>• SRH<br>• SGBV prevention and response<br>• Special needs | • Trained staff<br>• Senperforto Framework SGBV prevention & response | • Social protection<br>• Education (school health) | |

**Refugee Status Granted: Need to integrate migrants in the regular Health system (link to national health plan)**

| Health response | Minimum health services to be ensured | Basic equipment/supplies/ resources to be provided | Network/coordination tasks | ! Remember |
|---|---|---|---|---|
| Comprehensive PHC, SHC and THC and rehabilitative services | • Follow up of known illnesses (CD and NCD)<br>• Ensure start of treatment of newly diagnosed TB cases<br>• Health promotion<br>• Psychosocial support<br>• SRH<br>• SGBV prevention & response<br>• Special needs: disability… | • Female HRH<br>• Trained staff in health entitlements of migrants and cultural sensitivities<br>• Interpreter facility<br>• Health promotion materials in most prevalent languages | • NHA, RHA<br>• Specialised psychosocial services<br>• NGOs and volunteer organization<br>• TB surveillance coordination<br>• Social protection<br>• Education (school health) | • Ensure migrant awareness and understanding of health entitlements |
| ***Unaccompanied minors*** | • Psychosocial support<br>• SRH<br>• SGBV prevention & reponse<br>• Special needs | • Trained staff<br>• Senperforto Framework SGBV prevention & response | • Social protection<br>• Link with SGBV actors<br>• Education (school health) | • Signs/symptoms/<br>• behaviour changes due to violence, discrimination… |

**Undocumented Migrants: Need to integrate migrants in the regular Health system (link to national health plan)**

| Health response | Minimum health services to be ensured | Basic equipment/supplies/ resources to be provided | Network/coordination tasks | ! Remember |
|---|---|---|---|---|
| Comprehensive PHC, SHC and THC and rehabilitative services | • Follow up of known illnesses (CD and NCD)<br>• Ensure start of treatment of newly diagnosed TB cases<br>• Health promotion and prevention<br>• Psychosocial support<br>• SRH<br>• SGBV prevention & response<br>• Special needs: disability | • Female HRH<br>• Trained staff in health entitlements of migrants and cultural sensitivities<br>• Interpreter facility<br>• Health promotion materials in most prevalent languages | • NHA, RHA<br>• Specialised psychosocial services<br>• NGOs and volunteer organization<br>• Tb surveillance coordination<br>• Link with SGBV actors | • Ensure migrant awareness and understanding of health entitlements<br>• Particularly important in irregular migrants as they may postpone care out of fear or lack of finances |
| ***Unaccompanied minors*** | • Psychosocial support<br>• SRH<br>• SGBV prevention & response<br>• Special needs | • Trained staff<br>• Senperforto Framework SGBV prevention & response | • Social protection<br>• Education (school health) | • Signs/symptoms/<br>• behaviour changes due to violence, discrimination… |

# Annex 6

# Resource Package for ensuring access to health care of refugees, asylum seekers and other migrants in the European Union (EU) countries (draft)

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**SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC**

# RESOURCE PACKAGE FOR ENSURING ACCESS TO HEALTH CARE OF REFUGEES, ASYLUM SEEKERS AND OTHER MIGRANTS IN THE EUROPEAN UNION (EU) COUNTRIES

*Working document*

Draft 3, 13st June 2016








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## User's guide

- The present document aims at supporting individual EU Member States in defining the fundamental elements that ought to be present in the development of a resource package for ensuring access to health care of refugees, asylum seekers and other migrants in the European Union countries. This resource package aims to support the multiple national, regional and local stakeholders involved in the response to the health needs of refugees, asylum seekers and other migrants who are part of the recent influx into the European Union.

- This resource package speaks primarily to the national or subnational health authorities responsible for defining an operational strategy harnessing the contributions of different actors to the provision of accessible health care and the implementation of specific strategies and measures addressing the barriers to access to quality health care for these migrant populations. It is also intended for the different governmental and non-governmental actors as well as international and civil society organizations who participate in the national and local efforts directed at responding to the health needs of these vulnerable populations.

- Flexibility in the application of this resource package is highly recommended. Any governmental authority can select the parts that are relevant for their country/context and customise it to develop or strengthen their context-specific strategy to improve access to health care for refugees and asylum seekers.

- The context in which health professionals and managers operate is different from one country to the other and so is the situation for migrants. Information on available measures and tools contained in this resource package should be integrated in the national and local means of communications and established network of cooperation. Therefore the resource package proposed in this document is to be seen as a support tool for the development and dissemination of a resource tool at country/regional/local level, depending on its level of implementation.

- This resource package was developed and presented at the SH-CAPAC workshop on 16th and 17th June 2016 in Reggio Emilia, Italy and has since integrated the recommendations from the meeting and been adjusted to the new circumstances of the migrant flows. Another draft was discussed at the SH-CAPAC meeting on April 6th 2016 in Trnava, Slovakia. Further amendments may be needed in the future. Revisions will be made publicly available on http://www.easp.es/sh-capac/.

# 1 Why do we need to address the particular barriers faced by asylum seekers

For migrants, barriers to accessing healthcare represent a complex picture. It has long been recognised that newly arriving migrants may face special health risks and frequently do not receive the care they need. There are also important access problems faced by people living in temporary reception centres and by irregular migrants in general. Moreover, there are many challenges for providing healthcare to these vulnerable groups these include: complex legislative requirement for obtaining permanent status, lack of knowledge about available services; language and cultural barriers, administrative and bureaucratic factors, and mistrust of health providers, particularly for those fearing detection.

Norredam et al. (2006) argue that a wide range of pre- and post-migration risk factors contribute to increase the vulnerability of asylum seekers, particularly in their access to healthcare. Pre-migration factors include torture and refugee trauma, while post-migration factors may include detention, length of asylum procedure, language barriers, and lack of knowledge about the new healthcare system. As with other categories of migrants, these factors often interact with a component of deprivation in the host country. Asylum seekers also frequently experience social exclusion. A common aspect is that in most countries asylum seekers are entitled to at least basic treatment for acute diseases. Nevertheless, current regulations in some countries impose severe limitations on the entitlement of asylum seekers to healthcare services under public programmes. A consequence is that such changes in immigration policies may have a negative impact on access to healthcare.

# 2 The aim of this Resource Package

The present document is aimed at supporting EU Member States to address barriers to access to health care and to ensure continuity of care of refugees, asylum seekers and other migrants along the whole migration journey, from arrival to transit areas of reception, to regions/countries of destinations. This action aims to ensure emergency as well as routine treatment by facilitating access to mainstream services, to primary care services and ancillary services addressing specific refugees, asylum seekers and other migrants needs. It also aims to ensure the entitlement to health care for failed asylum seekers. These aims will be achieved through the development of a resource package based on available evidence and expertise involving health and social authorities, IOs and NGOs active in the field,

The objectives of the resource package are to:

- Provide evidence on the new challenges for health service related to the current refugee crisis
- Provide a framework and outline steps for improving access to health care for refugees, asylum seekers and other migrants.
- Provide evidenced tools and measures and other resources that can support MS addressing formal and informal barriers that hinder or limit the access to health care for refugees and asylum seekers

Three areas of interventions are particularly relevant: improving information and communication in critical settings of reception, by strengthening information methods and tools addressed at refugees and using interpreters and other mediation professionals, such as community health educators, link workers, and intercultural mediators. Secondly, it is important to improve the flow of information between different levels of reception centres, as well as between transition countries/regions and countries /regions of destination. Finally, there is a need to improve the knowledge and skills of interdisciplinary teams and sectors at various level (national/regional/local) in developing integrated strategies and interventions to ensure access to

health care for refugees, asylum seekers and other migrants. This goal will be achieved by the identification and later implementation of evidence based strategies and dissemination that are sustainable and suitable at local level.

# 3 Setting the scene: focus groups analysis and literature review

In order to gather information on the new challenges for health services related to the current refugee crisis a series of interviews and focus groups have been conducted in 10 EU countries between February and March 2016: Austria, Belgium, Italy, Spain, Greece, Hungary, Slovenia, Netherland, UK and Denmark. The focus groups and interviews had three main objectives:

- To identify the new challenges that refugees and health professionals are facing in relation to the current crisis and how the situation of asylum seekers impact on the accessibility of health care in the phase of arrival, transit and destination.
- To collect existing measures and tools that health services have put in place to deal with the challenges described;
- To collect opinions and views from potential users on what a resource package should contain and look like to support their practice as health professionals and managers

The interviews and focus groups were addressed to professionals working in center for refugees/AS, working in health services (primary care services, hospitals, health promotion/prevention) where AS go for health care, "hot spots" (persons intervening in "non-official" settlements), arrival camps (e.g. camps in border countries or landing countries), transit camps, destination centers, mental health services (general or specialized), physicians, nurses, psychologists, intercultural mediators/patient navigators/community health workers, services specialized in health care for victims of sexual violence, mother and child care, social workers (inpatient or outpatient services), volunteers for NGO, persons in charge of health services / head of health services / public officers in charge of health issues / refugees affairs at municipal/regional/national levels, civil servants working with ministries involved in health/justice/immigration.
The analysis of the interviews and focus groups results are summarized in brief country reports that provide an overview of the problems, solutions and needs of health professionals and health managers when providing health care and organizing service delivery for asylum seekers and refugees. These results provide clear indications on what should be in a resource package addressing the barriers to access health care services.

# 4 Challenges for health professionals and health care managers related to the current refugee crisis

- *Administrative issues related to the legal status of the asylum-seeker/refugee*

In some member states, the main obstacle is the legislation that limits access to health care for many categories of migrants and refugees (e.g. asylum seekers that are accommodated in the centre for asylum seekers, refugees in arrival centres, people placed in detention centres waiting for deportation or in the process of identification, migrants with permission to stay, that are released from the detention centre because they cannot be deported and undocumented migrants) only to emergency care.

All above listed groups of migrants/refugees may be excluded from the regular system of health care coverage and may only be entitled to emergency health care as defined in the International Protection Act.

In spite of that, the interpretation of emergency health care can be quite arbitrary, since the extent of provided services is often based on the particular decision of the health care worker that treats patient.

As stated before, lack of knowledge of the different statuses and their implications for health care as arbitrary decisions taken by care providers and public social welfare services may have a major impact on the accessibility of health care.

E.g. in Spain many incorrect responses regarding health care coverage and access have been given to asylum seekers in healthcare centres.

Many participants to the focus groups point out that the delivery of health care services to asylum-seekers, refugees and undocumented migrants is seriously hampered by the complexity of administrative procedures that have to be executed to guarantee access to care.

Different procedures have to be followed depending on the status of the asylum-seeker: as long as he has not been registered as an asylum-seeker (e.g. because she/he does not intend to stay in the country she/he is in at that moment) is considered to be an undocumented migrant. This implies that specific rules apply, which differ from one member state to another which in their turn lead to a number of administrative procedures that have to be respected to guarantee access to care. Countries such as Slovenia and Hungary notice that almost no asylum-seekers apply for asylum there.

Once someone has registered as an asylum-seeker, her/his access to care is – in most countries – guaranteed. In some, she/ he may even be eligible for reimbursed types of care – such as non-residential mental health care – that is not reimbursed for indigenous patients (this is e.g. the case in Belgium).

Once a person has been granted refugee status, she/he tends to have the same rights to health care as the indigenous population of the country involved. However, administrative procedures – such as a waiting period imposed by health insurance organizations – may make that the person is without health insurance for a relatively long period, rendering access to care difficult because of financial thresholds.

Asylum-seekers that have been refused refugee-status become undocumented migrants which will limit their access to health care services and will entail a lot of red tape for health care services that want to deliver care.

Member states point out that the legislation on the delivery of care for different types of asylum-seekers/refugees lead to a lot of extra strain and work for the care providers. In addition, care providers are often insufficiently familiar with rules and regulations that apply. There is not enough knowledge on the different administrative statutes of refugees and asylum seekers and what their health care rights are among medical doctors, nurses and social workers. As a result, patients may not receive the care they are entitled to. It is further pointed out that these rules may be unclear and in some countries change often. Institutions outside the health care system may be involved in granting access to health care services such as public social welfare centres. They may have final say in health care reimbursement matters e.g. in Belgium. These issues are of particular relevance to undocumented migrants.

Some institutions and individual care providers seem to act randomly and the existing legislation is interpreted differently. Individual views of care-providers on the presence of asylum-seekers or migrants in society, often influenced by the media and political discourse may have an important impact on the accessibility of the health care system for migrants.

Information on the different legal statuses of migrants and their impact on access to health care is – in different countries – not readily available for care providers and is inefficiently spread to health care managers and care providers alike.

In particular care providers argue that administrative procedures and legal limitations to the different types of care an individual patient may be entitled to, put a strain on the care delivery process. They may have to explain why certain types of treatment cannot be given or certain drugs cannot be prescribed.
When legal and administrative procedures are not respected, this may have far reaching consequences for the health care institution that may not be reimbursed by the state for the services delivered.

- *Linguistic and cultural barriers*

Linguistic and cultural barriers are systematically identified as one of the major challenges related to the refugee crisis. In many Member States no or insufficient professional interpreters or intercultural mediators are available. In practice interpreting/intercultural mediation is often carried out by NGO members (e.g. in Greece), volunteers, other refugees or professionals) who have not been trained in this domain (e.g. psychologists, educators).

Many problems related to this situation are being reported. Care often has to be provided on the basis of poor communication. Providing care without interpreters/intercultural mediators takes up a lot of time which leads to long waiting times for the other patients. Diagnoses and the necessity of (a long) treatment cannot be adequately communicated. In one Greek focus group the case is presented of a child with a brain tumor and the impossibility to explain this to the father. As long-term treatment may impede the asylum seekers possibility to continue their journey to the country they would like to settle in, without adequate communication parents may decide to take their sick children with them. Certain diagnostic tools – e.g. psychological tests for traumatized children or children with emotional problems – cannot be used making the work of psychologists very difficult or impossible.

Rare are the member states where care providers have institutionalized intercultural mediators of interpreters at their disposal. Even where this is the case, as it is in Belgium, the number of mediators / interpreters is too limited and care providers may be insufficiently aware of the possibility to call them in. Some care providers – in particular in mental health services – refuse to work with interpreters / intercultural mediators. It proves to be difficult to make care providers rely systematically on professional intercultural mediators / interpreters. This is the case for 'on site' intercultural mediators / interpreters and even more for remote intercultural mediators or interpreters who intervene by phone or with the aid of videoconference technology.

The impossibility to resolve linguistic barriers makes it extremely difficult to handle cultural barriers that may further impede the care delivery process. Care providers have received insufficient training in cultural competence and may be completely unfamiliar with patients coming from the Middle East. There also seems to be a need to share information on cultural issues acquired by care providers. The lack of cultural competence seems to be most problematic in mental health care, making it difficult to provide adequate care for refugees with mental health problems such as PTSD.

As some patients coming from e.g. Syria and Iraq may sometimes vehemently refuse to be treated (or have their spouse) treated by a care provider of the other sex, it may be important to have a sufficiently high number of female providers present. This is particularly relevant for the gynecology department.

Rescuers in Lesvos reported that in some cases they cannot provide first aid to drowning women as their men do not permit the rescuers if they are male to untie some of the women' clothes. These cultural issues, cause problems to their work as they argued.
Due to cultural reasons, patients may be unwilling to discuss issues that lie at the heart of their mental health problems. Differences between the medical culture of countries such as Syria/Iraq lead to conflicts

with MD's. Antibiotics e.g. can easily be obtained in Syria. And pharmacists have a role that is very similar to that of MD's working in primary care in (Europe) Belgium.

There is a lack of quality information for workers on new healthcare pathways and on the existing possibilities in the region where people can be directed. There is a lack of quality information for asylum seekers/refugees on how to navigate the health care system.

- *Lack of information and difficulties to ensure continuity of care*

Asylum-seekers often arrive, as well at the arrival, transit or settlement phase, without any health records. The identity given by patients may not be real. Care providers often do not have reliable information on the illness and treatment history of the patient.

Absence of information on the vaccination status of children is a problem that is systematically reported. In some countries refugee children coming from Africa and Afghanistan were systematically vaccinated as providers knew that many –if not most- of them had not been vaccinated. Children coming from Syria – where the health care system used to function well – are also vaccinated although this may not be necessary. This because no health records are available and it – due to language barriers – it is impossible to obtain information form the parents.

Patients often move from one country to another during their asylum-seeking process. Even when they are settling in a country, they may move from one place to another as countries may have policies to distribute refugees over their whole territory. Moving makes it difficult for care providers to set up extensive treatments.

No adequate systems for the exchange of medical information between member states exist. Even within one country moving from one place to another, or from one type of health care institution to another (e.g. from a medical service in a refugee camp to a regular GP), may entail the loss of highly relevant information on the illness and treatment history of the patient. In countries where computerized medical data systems exist, different databases may not be connected and impossible to consult by care providers.

As a result, partial and fragmented care is often provided and the right to health (care) not fully guaranteed. Ideally, information on patients (documents, medical records, clinical background, treatment, …) should 'travel' with the patients. This is not the case. Information is patchy and patients cannot be looked after comprehensively with the risk of errors being made and inadequate care being provided.
In particular in countries of transit (e.g. mainland Greece), asylum-seekers may leave the hospital or stop the treatment – against the care provider's advice - to be able to continue their journey with their compatriots. This may also be the case for children. It is often impossible to trace these patients as they may have registered using different names and as no address or phone number is known.

- *Organization, quality and coordination of health care services*

In countries where a lot of care is provided by volunteers or by international NGO's (reported by Hungary and Slovenia) the quality of care may be of very uneven quality. In Slovenia, for example Hungarian care providers worked in mobile hospital units that were very well equipped and had sufficient supplies of medicines. Other patients had to be treated in the mud in the open. The presence of different NGO's and groups of volunteers in combination with a lack of organization may result in chaos and too little collaboration between the different care providers.

Complex administrative procedures related to the provision of medical care to refugees leads to extra costs for health care institutions that are not taken into account by the funding authorities. As in most countries,

no supplementary health care services have been organized, capacity problems seem to occur. This situation may affect the services available for the indigenous population. Indigenous patients are reported to complain about the presence of refugees in health care institutions which lead to longer waiting times.

MD's point out that refugees may only need minor forms of treatment and will delay care delivery to indigenous patients who are really in need of emergency care. This seems to be particularly the case on the island of Lesvos where very high numbers of refugees arrive.

In Slovenia, it was reported that the inappropriate response of the authorities and the chaotic conditions daily covered by different media together with the lack of knowledge about other cultures strengthened two concerns among the people: that refugees can spread contagious diseases and that they pose a serious security threat. These sometimes even prevented health care workers who wanted to help refugees to do so, since they faced a lack of support or even strong opposition from their families or employers in case of working in arrival centres.

Poor management of the refugee crisis in health care is said to lead to overcrowding of certain hospitals. Burn-out syndrome and compassion fatigue are being observed in care providers working with refugees. They report that they feel emotionally burdened when they meet refugees 'they cannot help as much as they would like to'.

Refugees are also reported to rely on health care services to solve a number of problems that are clearly situated in the social domain. Issues of housing and administrative problems are often presented to health care providers as they seem to be the single (positive?) point of contact with the host society. Health care institutions in some countries argue that there is a lack of collaboration between social and health services to improve the living condition and health of the refugees.

It is pointed out that care providers should be alert to recognize diseases that are uncommon in the receiving countries but may be so in the countries of origin of the refugees.

In Belgium some private hospitals do not want to treat refugees and asylum seekers because the risk for non-payment and the administrative burden. This leads to unacceptable situations such as a pregnant woman about to give birth being quickly transferred to a public hospital by ambulance.
Access to specialized care (for instance dental care, ophthalmology, orthopedics, physiotherapy) is sometimes hampered by the fact that care providers are allowed to set their own fee: the state only reimburses amounts fixed by the national health insurance system for asylum seekers. As a result, specialists may refuse to treat them.

# 5 Specific impact on accessibility of different phases of the migration process

A person's administrative status seriously affects her/his rights and access to health care services in member states. This may be related to the phase of the asylum seeking process the person is at in a certain country. E.g. they may avoid to register as an asylum seeker in these countries they do not wish to settle in and this in turn may affect their access to health care.

*Arrival phase*
Usually, all asylum seekers entering a member state are entitled to free of charge emergency health care. During the arrival phase, healthcare professionals may have to intervene on site, as asylum seekers may not manage to find the health practitioner's office.

Proper information on their right on access to health care/ health assistance should already be provided at that stage. Unfortunately this is often not the case.

Sometimes bureaucratic registration procedures take about 6 months – during this time span, refugees are not health insured. They may not yet have asocial security number, which may have an impact on accessibility of certain types of prescribed drugs.

During the arrival phase, Doctors of the world and Doctors without borders along with other NGO's from different countries provide primary health care services in a number of member states. The emergency situations end up at hospitals. In countries where large numbers of asylum seekers arrive (at the time of the FGs in particular in Lesvos/Greece), this may be problematic because of the high number of patients to be seen.

Because of the increase in number of asylum seekers arriving in Slovenia, refugees were being accommodated in additional units of the centre for asylum seekers. In contrast to the main unit, there were no nurses or doctors present there. As a result, asylum seekers who may need psychosocial support, or medicines for treatment of chronic conditions often visit emergency units of health care centers. This increases bias and prejudice towards migrant population, since they are regarded to be undisciplined patients who are exploiting and misusing emergency units for problems that are not urgent.
Because of limited time in this phase, 'emergency' care with absolutely no integration is provided. It is impossible to get a complete clinical picture. Often chronic diseases or mental disorders and immigrants' personal plans are not taken into account.

*Transit phase*
Registered asylum seekers are entitled to free of charge primary health care. Because of the lack of information, in the transit phase/ at the transit areas health care professionals may have to go on site in order to treat asylum seekers in transit arriving in their country, as they may not be able to find their way in the health care system. The asylum seekers who live in camps get healthcare in the camp.

In many member states NGO's provide primary health care services on site during the transit phase. If the health problem is considered serious, the migrant/refugee is taken to the hospital but they may not complete their treatment as they want to continue their trip to Northern Europe.

Personal medical files (e.g. on vaccination status) are rarely available. So in every new health institution, all of the relevant information needs to be collected again. This is a waste of time and dangerous in urgent situations. As a result, treatment of chronic diseases (e.g. cancer, aids-HIV, diabetes,…) is often inadequate.

Refugees Reception Centres are facing a double problem. On the one hand, the flow of information among professionals from the different centres is incomplete and often late and on the other hand, they have noticed that refugees do not always understand the doctor or care provider.

There is little chance of implementing prevention and promotion programs offered by the public health system. The focus is on acute health issues and communicable diseases.

No psychological counselling to help refugees deal with the traumatic experiences of the exodus is available or it is very difficult to receive.

Time is one of the main challenges when it comes to asylum seekers in transit to access and be assisted by healthcare services. More specifically, pregnant women are urged to take specific tests that assess their and their babies' health. Taking into account the waiting times and protocols of our system, the access to these services (e.g., gynaecological consultations, ultrasounds, and analytics) is very complicated. The same challenge exists for urgent psychological assistance and mental healthcare.

The information reported by people who are in transit may be confusing. For example, they state that they intend to stay for a month but may leave two days later.

*Destination phase*

Once an asylum-seeker has been granted refugee status, he has the same entitlements to care as all legal residents. In some countries, this may imply that types of services that were provided free of charge before the recognition, will have to be paid for by the refugee. This is e.g. the case for non-residential mental health care services in Belgium and leads to financial barriers.

At this stage, the refugee will lose much of the assistance she/ he may have received during the previous phases (e.g. to make use of social and health care services). Insufficient knowledge of the health care system and cultural differences often hamper access to health care. Now, she/he will be expected to make use of main stream health care services unaided. This will in many cases be problematic as the refugee's limited health literacy makes it hard for him to navigate the bureaucratic and complex health care system.
Linguistic and cultural barriers described above negatively affect access and quality of health care services also at this stage. The effects of these barriers are aggravated by the limited culture competence of many care providers. The lack of understandable information for refugees on the organization of social and health care services further complicates their access to help they may need.

# 6 Specific health situations in which specific challenges arise

1. *Sexual and reproductive health*

The follow-up of the relatively large number of pregnant women in arrival camps seems to be a major problem. Participants' experiences with them are the eloquent proof of how conditions in arrival camps influence the refugees' health and trigger the problems instead of preventing them. In Spain e.g., many pregnant women had cramps and doctors mistook them for labour contractions. They were taken to the maternity hospital and examined by ultrasound, but the cramps appeared to be a consequence of the women lying on the cold floor. E.g. In UK prenatal care can be charged. There is a payment plan in order to help refugees pay it back. Some pregnant women are only registered in the health service system at a late stage in their pregnancy. Mothers with babies need to be redirected to the available support services.

2. *Mental health care*

Regarding the situation and traumatic experiences many refugees encountered before and on their journey, focus group participants working in arrival camps meet many refugees with mental health problems in need of psychosocial assistance and support. A woman from Syria said that her village was completely destroyed. She said that there were a lot of dead bodies in the streets and hygienic conditions deteriorated. In addition, they were running out of food. They could not feed their animals, so dogs started eating the dead and after that attacked the people who were alive. Refugees were not living in normal situations and are in need of mental health care.

Repressive police and army actions (unexpected replacements of people without informing them, officers carrying weapons, police helicopter flights etc.) furthermore stimulated re-traumatization among refugees, which resulted in many interventions of health care workers and volunteers that could be preventable. In spite of all that, there were no appropriate professionals (psychologists, psychiatrists, therapists etc.) in arrival camps who could adequately address refugees' needs. If they were, however, they were not always able to perform their activities due to the repressive police approach, which was at the forefront of work organization in arrival camps. As a result many people waiting to get medical help did not actually need it,

but were in extremely hard circumstances only looking for a support, human contact, information, food, water or dry clothes and shoes.

Similarly, there is no adequate care addressing mental health needs of asylum seekers that are transferred to the asylum centre. Special care, including psychotherapeutic one, can in some countries be covered, but only in limited range to so-called vulnerable persons with special needs (disabled people, elderly, pregnant women, single parents with minor children, victims of trafficking, persons with mental health problems and victims of rape, torture or other serious forms of psychological, physical and sexual violence) and on condition that a special commission approves it. Despite the fact that there are psychologists employed in some centres for asylum seekers, there are no generally accessible specialist therapies for traumatized refugees. They may only be able to access them only if a general practitioner writes them a referral which is connected to many barriers (long waiting periods, lack of translators/intercultural mediators, lack of cultural competent specialists etc.). There are some NGO's such as 'Freedom from torture' offering mental health care for refugees but the waiting lists are too long.

An additional difficulty during the psychological treatment is associated with the differentiation of psychosomatic symptoms derive from post-traumatic stress disorder of physical illnesses. It's complicated to discriminate between physical, psychological and social issues in this population.

3. *Refugee children/Unaccompanied minors*

According to state regulation in Spain minors should receive specific protection due to their high vulnerability. To ensure that they are minors a "bone age assessment" is necessary, which could have a large margin of error, making it difficult to determine their real age. Since this bone age study can be a source of anxiety and it isn't reliable at all, it is considered necessary to look for new complementary ways of establishing migrant's age.

*4. Victims of violence*

In Spain the implementation of the Istanbul Protocol as a way to prove that they had suffer torture is a challenge due to the high cost (2.000€ - 3.000€) of the expert report. The cost is not covered by public service, so social organizations must paid for it.

High rates of violence against women and sexual violence are reported for asylum seeking women. There is some evidence that young men are also at risk for sexual abuse.

# 7 Existing measures and solutions

A number of measures that are currently in place in the countries involved in the focus groups could be potentially helpful in addressing the needs of asylum seekers and improving their situation.

First, it is important to enlarge the health care services made available to asylum seekers. Some countries currently offer only acute treatments. However, this should be expanded to encompass more healthcare services, particularly mental health services, in view of the pressing healthcare needs of asylum seekers.

Second, it is necessary to reduce the complexity of the legislative framework and administrative procedures in order to ensure entitlements to health care (acute and chronic) for those in the process of applying for refugees status, those waiting for a decision on appeal and failed asylum seekers.

Third, it is fundamental to ensure the availability and quality of language and communication support services including the use of interpreters, intercultural mediators and/or Community Health Educators.

Fourth, culturally sensitive training aimed at improving the coping skills of asylum seekers is required to improve health and deal with the health deterioration and mental health problems frequently observed after arrival. This should take into account the interaction between physical and mental health symptoms.

Finally, it is necessary to consider the impact of policies of relocation, in particular, it is important to provide support to healthcare providers for asylum seekers who are in transit; this might require, for instance, that patient information is appropriately recorded and made available to the new provider. Country reports suggest to develop an information system and tools in order to ensure the effective flow of information regarding health situation, psychosocial condition and individual and family migration project between different levels of reception centres and between transition and destination countries/regions.

| **Measures and solutions collected in 10 EU countries** | **Services** | **NGOs** | **Partnerships** |
|---|---|---|---|
| To address legislative, administrative and bureaucratic factors | 3 | 0 | 2 |
| To address language and cultural barriers | 2 | 3 | 1 |
| To address lack of information and continuity of care | 0 | 2 | 0 |
| To address organisational barriers to health service (hospital + primary care) | 2 | 3 | 1 |
| To address lack of organization and collaboration between services | 3 | 5 | 2 |
| To improve information and education for both staff and refugees | 5 | 2 | 2 |
| Total | 15 | 15 | 8 |

# 8 Development and dissemination of a Resource Package

## 8.1 The content of a resource package

The information and opinions collected from health professionals and managers working with refugees and asylum seekers provide a clear picture of what is primarily needed in the field to overcome the barriers to access health care services. Five most important areas have been identified:

1. **Linguistic, communication and intercultural issues**: guidance on interpreting and intercultural mediation services, other communication supports and how to use them (e.g.: written translations).
2. **Training staff at all levels**: guidance on training for health professionals, health managers and administrative staff about intercultural competences and specific issues concerning the health needs of asylum seekers and the health care responses.
3. **Information for health professionals and migrants**: guidance for health care workers regarding health issues, services available, and legislative/administrative issues affecting the access to health care for asylum seekers; information and education interventions for refugees and asylum seekers on their rights to health care and available services, taking into account health literacy.
4. **Legislative, administrative, bureaucratic and financial issues**: information on legislative, administrative, bureaucratic and financial factors that needs to be tackled to ensure equitable access to health care.
5. **Organization and continuity of care for quality services**: development of strategies for systematic record and traceability of patients' information; improvement of coordination and networking between different services and actors at local, national and international level.

*1. Linguistic, communication and intercultural issues*

Since language and culture barriers are one of the biggest obstacles in providing comprehensive and quality health care to refugees, the introduction of a large number of professional interpreters as well as intercultural mediators in EU health care systems is necessary. The employment of translators and/or intercultural mediators should be systematic at all levels of care to facilitate the communication and understanding between health workers and migrants. It could also represent an opportunity for refugees to become mediators, since they know better their culture and language. The system should be systematic (EU facilitated) and centrally funded (Ministry, local communities, EU funds). However a successful employment of intercultural mediators is inseparable from the development of a cultural competent system of care.
It has been suggested that the resource package should contain information on different models for implementing interpreting services (e.g.: face-to-face and telephone/video interpreting, intercultural mediation, etc.) and information about specific tools to facilitate medical consultations (e.g.: anamnestic questionnaires to gather the medical history of the patient; multilingual posters to aid migrants to explain their symptoms and health needs). Translation tools shouldn't be focused only on health care but also including administrative procedures in general.

*2. Training staff at all levels*

Training health professionals, managers and administrative staff has been highlighted by almost all interviewees. The implementation of training courses on cultural competence is urgently needed in particular in those countries mostly affected by massive arrivals (e.g.: Greece) and those countries that are relatively new to immigration influxes, e.g.: Hungary, Slovenia. Participants recognized empowerment as important

concept, since they feel that they do everything on their own without any planning, limited resources and limited staff.

Specific contents have been indicated as fundamental topics in a training package:

- intercultural communication skills, including respect for diversity as a value, stereotypes, prejudice, cultural diversity; social and communicative skills, including empathy; skills to improve the occupational well-being of providers working at fundamental risk situations
- national legislation and administrative procedures that have an impact on access to health care
- asylum seeker migration phenomenon
- disease and health problems affecting asylum seekers
- mental health and psycho-social needs of asylum seekers, particularly unaccompanied minors
- broader approach to diagnostic to acknowledge the psycho-social wellbeing of migrants
- staff empowerment and skills development to cope with stress since they often work without service coordination and with limited resources and personnel
- collaborative capacity-building between multiple stakeholders to promote available community resources and services in the territory.
- interpreting services, including meetings with group of patients to apply the previously learned contents.
- short-term emergency response and long-term strategies aimed at the integration of migrants in the National health care system, to reduce inequalities in health and ensuring equal access to health care services.

The courses could be spread nationally through GPs' and other organizations, and they should be free of charge or for a small fee to stimulate a greater participation. Academic Institution (Nursing, Medical schools, etc.) should integrate such courses in their existing Programs and e- Learning courses will be appreciate as well.

*3. Information for health professionals and migrants*

Since many health professionals work in very poorly organized settings they stressed the need to obtain information not only on the health situation of asylum seekers but also on services, resources available and administrative/legislative issues. The main information needed is about:

- organization and access to particular health services such as: vaccinations, reproductive health, sexual violence, victims of torture, and female genital mutilations
- available services and resources from other sectors (e.g.: housing, schooling, etc.)
- emergency plans to improve the health care response and guarantee an effective access to health care for asylum seekers
- current legislation (country-specific: national and local level) concerning refugees and asylum seekers, both basic laws and the process of administration; legal status of migrants and its effects on access to healthcare services including their entitlements (e.g. reimbursement/exemption of health care costs, etc.); the law on personal data; universal right to health care and international treaties.
- guidance for the design and implementation of a System to keep track and monitoring migrants entering in the health care system. Participants suggested that some kind of European or national cohesive IT system should be created to enable the storage of relevant medical information about asylum seeker and refugees. Migrants transit rapidly throughout the countries and for files to be

transferred with them may take many months. Therefore participants suggested a sort of passport or digital ID card that can be used to easily access medical information.
- best practices with concrete examples of successful strategies in European contexts and the main problems/barriers to access health services.
- financial support and financing for migrants health in different countries.

Participants mentioned the creation of tools to improve migrants' knowledge about the health care services, like: mobile applications; self-help products (e.g. tool-boxes to handle stress and panic attack, involving the media with graphical contents, etc.); courses to provide all the useful information about the health care system and the possibilities to access health care institutions; brochures for specific diseases like diabetes, pregnancy, the first time at the GP, etc.

4. *Legislative, administrative, bureaucratic and financial issues*

A resource package should contain practical guidance on how to overcome administrative barriers and clearly outline what procedures have to be activated to ensure access to care to these vulnerable groups.

5. *Organization and continuity of care for quality services*

Results from the focus groups discussion highlighted the need of indications for policies and procedures regarding:
- the design and implementation of an information system capable to keep track and monitoring migrants entering in the health care system. Participants suggested that some kind of European or national cohesive IT system should be created to enable the storage of relevant health information (documents, medical records, clinical background, treatment, etc.) about asylum seeker and refugees. Migrants transit rapidly throughout the countries and for files to be transferred with them may take many months. Therefore participants suggested a sort of passport or digital ID card that can be used to easily access medical information.
- a tool for mapping the different stakeholders (International Organizations, National Health Systems, NGOs, etc.) and create platforms for sharing the work-load and expertise between countries and at local level.
- guidelines for health care workers to deal with particular vulnerable groups (e.g. mental health disorders, unaccompanied minors, victims of torture and sexual violence, women with genital mutilation, etc.) including support for the implementation of a referral system for such patients.

## 8.2 Format of a resource package

Participants to the focus groups and interviews proposed various formats for a resource package. It seems that the best solution is a country-specific format, that fits with National and local settings, and existing communication strategies. Face-to-face interventions, training sessions and workshops have been identified as more effective rather than other mediated tools -such as brochures, websites, etc. Conversely for some of the participants, online courses –even as part of mandatory training- would be similarly efficient to improve some specific communicative and educational skills. Booklets and leaflets, as well as other paper materials that are easy to disseminate and immediately accessible (with no need to use Internet) might be useful for those health care professionals who are unfamiliar with the Web.

Focus groups' participants have also identified others relevant instruments like: presentations, booklets, brochures, resource briefcase, protocols with decision trees, interactive blogs, websites, intranet, help-lines, learning management systems, tutorial videos, forums for sharing different expertise and connecting professionals with different skills, mobile application for professionists, national and international workshops, and symposiums hold by key stakeholders on regular basis.

The resource package should be aimed to train rather than educate and it should be more experiential than informational. Indeed the general objective should be to raise awareness and to provide participants with skills and capacities to react and answer to real situations, instead of saturate them with theories and concepts. It is recommended to conduct the training in healthcare centers, communities, and social organizations, creating learning communities in healthcare centers, or organizing focus groups. These must be common spaces for a two-way-training where all stakeholders can participate. Participants also recommend the collaboration with experts and professionals from other contexts.

It has been highlighted that a relevant training course should be part of the emergency preparation programs. Moreover it should be provided not only to professionals already involved in migrants' assistance, since it could be important for all the health care professionals, social workers and other different stakeholders. Courses should be offered during office hours so they do not imply extra working time or conflicts with family life. Furthermore they should be continuous due to the high mobility of providers who work in healthcare and social organizations (e.g., transfers).

Finally, it was emphasized that whatever format will be selected, the resource package should be short, simple, cheap and easy to access.

## 8.3 Professionals targeted by a resource package

Participants of the focus groups identified different actors to whom submit the resource package in order to maximize its impact. Almost everybody agreed that the resource package should target all the health care workers, administrative staffs, managers, representatives of humanitarian and faith-based organizations, civil society, volunteers, and academia.

In the short term front line professionals who are already working with migrants would immediately benefit of new sources because they are willing to improve their daily practice; while in the long term health care managers and many more experts may take advantage of the resource package, and supervise its implementation. Moreover, at organizational level, translators, intercultural mediators and social workers should be targeted as well since they act as spokesman of users, they maintain a continue contact with migrants and administrative staff, and they are also members of multidisciplinary team.

Migrant-sensitive policymakers and national governmental institutions are key entities to take the discourse at political level, promote the dissemination and ensure the adoption of the resource package.

At community level it is valuable to take into account all members and actors of communities, different civil and social movements.

The contributions from different perspectives are needed, since barriers to access the health care by migrants depend on heterogeneous factors and challenges. Indeed a culturally competent health care

workforce will help to improve access, and quality health care outcomes while contributing to the elimination of health disparities.

## 8.4 The dissemination strategy for a resource package

Concerning the most effective strategies to disseminate the resource package, the respondents argued that it would be useful to count on providers from different backgrounds to act at many levels (e.g. policy, organizational and community levels) and settings (e.g., health and social sector, universities, counselling, etc.). They also asserted that the resource package should be selectively and geographically disseminated, even through existing networks of people who work in that field.

At policy level, it would be useful to include the resource package among the existent training programs, current healthcare plans, existing national websites and communication strategies. It could be disseminated through the Ministry of Health, national and local health professional organizations, national schools of Public Health, Universities, NGOs during team meetings or board meetings. As mentioned previously, participants considered the political discourse a powerful tool to promote this package. The creation of a specific and up-dated platform will help the follow-up, in addition to the participation in forums and the elaboration of reports.

Furthermore the cooperation between different Faculties (e.g. Ethnology and Cultural Anthropology, Medicine, Health Sciences, Education, etc.) is considered relevant since students' opinions and experiences could have a wider social influence. The resource package should be included in undergraduate and postgraduate trainings for health professionals.

At community level, neighbourhoods' community action centres and community health roundtables may play a crucial role.

The main strategy to inform the widest audience however is to make use of the media (mainstream and social), involving public figures to raise awareness and sensitize citizens to look at this vulnerable population as human beings having the right to be integrated in our society. The media have the biggest impact on the public opinion, and they are seeing as an essential channel to transfer information and knowledge. Someone argued that it might be helpful to show short video-clips through hospitals TV-screens to inform patients and care-providers. Mobile units have been also mentioned as they may contribute to disseminate the resource package.

Finally respondent stressed that the resource package should be economically accessible to everybody at all levels. Such inter-sectorial and integrated approach could therefore encourage the diffusion of information, the creation of alliances and synergies, the sharing of planning, the exchange of good practices.

# 9 Literature review

A literature review is performed on strategies and measures to improve access and quality of health services for refugees and asylum seekers developed between years 2008-2015 at a regional, national and/or European level (See Appendix II for a schematic overview made per source).

***Methodology***

**Source of information:** MEDLINE, EMBASE, CINAHL, COCHRANE

**Searched areas:**

- Barriers to access to health care for asylum seekers and refugees
- Effective interventions to overcome barriers

**Number of references included**: European studies/systematic reviews 38; extra EU studies and systematic reviews 143

| Barriers/intervention | EU papers | Extra-EU papers |
|---|---|---|
| Access to health services | 4 | 21 |
| Legislative/administrative/financial | 1 | 11 |
| Language/communication | 5 | 10 |
| Information/education | 2 | 11 |
| Organisation/coordination of service delivery | 7 | 15 |
| Mental health services | 4 | 17 |
| Sexual and reproductive care | 3 | 18 |
| Unaccompanied minor/Child care | 1 | 4 |
| Chronic care management | 2 | 5 |
| Prevention/health promotion | 8 | 22 |
| Violence | 1 | 9 |
| **Total** | **38** | **143** |

# 10 Concluding remarks regarding the Focus Groups and literature review's results

The results of the focus groups and interviews conducted in 10 countries clearly show that a resource package containing tools and measures to improve access to health care for refugees and asylum seeker should be developed at National/local level. The context in which health professionals and managers operate is different from one country to the other and so is the situation for migrants. Information on available measures and resources useful to support the access to health care should be integrated in the national and local means of communications and established network of cooperation. Therefore the resource package proposed in this document is to be seen as a support tool for the development and dissemination of a resource tool at country/regional/local level, depending on its level of implementation. Furthermore, national governments should allocate funds to improve the support to people already working with asylum seekers and to develop plans to improve integration in society of asylum seekers.

# 11 How to develop supportive strategies and effective measures at local level

**Supportive strategies and effective measures to overcome linguistic barriers**

There is a high degree of commitment among organisations to improve access to health care, but it can be difficult to know where to start. Implementing effective strategies to overcome barriers is a method of improving health care access. …..This resource package draws on the experience of health professionals and services gathered by the focus groups and literature review conducted for the SH-CAPAC project.

**Step-by-step guide**

- Select the refugee context of care: arrival, transit, destination
- Evaluate the current situation and develop a sense of urgency (overview of the evidence on critical issues in inter-cultural communication)
- Establish a working group (members and tasks)
- Create a shared vision for the ideal strategy to implement the improvement measures
- Identify individual measures and teams

**Resources for managers and for health professionals**

- Tool 1: Developing a vis-à-vis interpreting service
- Tool 2: Developing a telephone interpreting
- Tool 3: ……

**Case studies**

Two/three case studies highlight how different organisations have implemented the strategy/measure (e.g.: Belgium or Emilia-Romagna intercultural mediation service)

**Tips for success**

It offers learning from previous experiences who have implemented the strategy/measure on the critical success factors for this work and common pitfalls and barriers.

**Gaining support**

It summarises what previous experiences felt were the key influences on the success of the strategy/measure implemented.

**Mentorship and Join the group of experts**

Access to a group of people (network of experts/organisations) to share their experiences of the strategy or measure or to find out more about their approach.

## 12 Operational guidance to address barriers to health services

**Table 1: Developing a resource package to improve access to health care**

| Barrier to be addressed | Supportive strategy | Step-by-step guide | Effective measures | Case studies | Tips for success | Gaining support |
|---|---|---|---|---|---|---|
| **Language and cultural barriers** | | | | | | |
| **Legislative, administrative and bureaucratic barriers** | | | | | | |
| **Organisational barriers in health service delivery** | | | | | | |
| **Lack of collaboration between services** | | | | | | |
| | | | | | | |

| Barrier to be addressed | Supportive strategy | Step-by-step guide | Effective measures | Case studies | Tips for success | Gaining support |
|---|---|---|---|---|---|---|
| **Lack of information for refugees and asylum seekers** | | | | | | |
| **Lack information and continuity of care** | | | | | | |

## 13 Operational guidance to address barriers to specific health care needs

**Table 2: Developing a resource package to improve access to specific health care**

| Barrier to be addressed | Supportive strategy | Step-by-step guide | Effective measures | Case studies | Tips for success | Gaining support |
|---|---|---|---|---|---|---|
| **Mental health care** | | | | | | |
| **Sexual and reproductive health** | | | | | | |
| **Communicable diseases** | | | | | | |
| **Victim of** | | | | | | |

| Barrier to be addressed | Supportive strategy | Step-by-step guide | Effective measures | Case studies | Tips for success | Gaining support |
|---|---|---|---|---|---|---|
| **violence care** | | | | | | |
| **Child care** | | | | | | |

# Annex 1

# RESOURCE CENTRE

### 5.1. MEASURES TO ADDRESS LEGISLATIVE, AMMINISTRATIVE AND BUREAUCRATIC FACTORS

The obstacles registered in this issue are about the complexity of administrative procedures that have to be executed to guarantee access to care and that are very different depending on the status of the asylum-seeker. In particular there is not enough knowledge on the different administrative statutes and the health care rights are among medical doctors, nurses and social workers and there are different kind of interpretation of the existing legislation.

**Educate the doctors on the different types of legal status and asylum procedures**
(Brussels, Belgium)

**Service/department in charge of the measure:**
MEDIMMIGRANT (NGO) and FEDASIL (Federal Agency for Asylum Seekers).

**Description of the measure:**
Information session on the different types of legal status, their impact on access to health care and the required administrative procedures. The information can also be consulted on the internet. Moreover, Med immigrant provides information via a helpline.

**Expected outcomes:**
Time-saving and better understanding of the situation and the current legislation. Better access to healthcare. Doctors are more willing to help asylum seekers and refugees.

**Resource needed for implementation:**
Ideally, funding to hire staff to inform care providers.

**Voucher for one free consultation for undocumented / uninsured patients**
(Brussels, Belgium)

**Service/department in charge of the measure**
This strategy was implemented by the social service in one hospital.

**Description of the measure:**
Every patient has the right to one free consultation without any administrative or financial barriers. During this consultation, the physician will decide whether medical care is urgent or can be delayed. If necessary, administrative strategies will be developed to guarantee access to health care.

**Expected outcomes:**
The goal was to guarantee easy initial access to health care, as well as to remind (undocumented/uninsured) patients of their rights and to remind doctors that health care is a human right.

**Resources needed for implementation**

Commitment from the management of the health care institution, political decision for implementation in the country.

**Sensitization strategy aimed at administrative and healthcare staff of healthcare centres.**

**Service/department in charge of the measure:**
Technicians from the CAR in Seville (in collaboration to the Andalusian School of Public Health)

**Description of the measure:**
To sensitize administrative and healthcare staff of healthcare centres in order to increase their knowledge and empathy skill so to offer a better assistance to users.

**Expected outcomes:**
Increase the knowledge and empathy of the target population.

**Achieved outcomes:**
The organization disposed personal and material resources. Difficulties were found when trying to reach all collectives (e.g., problems with schedules, shifts, permits, etc.).

**Resource needed for implementation:**
Better dissemination means that allow developing better sensitization campaigns.

**Mediation and accompanying program**
(Seville, Spain)

**Service/department in charge of the measure:**
Sociocultural mediator

**Description of the measure:**
To reduce accessibility barriers in regard to administrative procedures through mediation and accompanying activities.

**Expected outcomes:**
Reduction of difficulties in the access to administrative procedures.

**Achieved outcomes:**
Difficulties were found in the personal characteristics of the administrative staff working in the registration windows.

**Resource needed for implementation:**
If there were more people working in mediation, results would be better.

**Responsibility for administrative, interpreting, and financing issues taken from health care staff by management**
(Austria)

**Service/department in charge of the measure**
Hospital directors / hospital management

**Description of the measure**
In Salzburg, the contact point interpreting services and intercultural care has taken over the responsibility to

organize transport of refugees and asylum seekers after out patient treatment in St Anna Kinderspital, hospital directors have told staff: the patient comes first. If the patient can't show the right documents/health card, copy as many documents as available and treat him/her. Management will organize financial issues. A "refugee pharmacy depot" was implemented, providing 25 most common drugs for minor health problems; documentation is done with a list, no additional bureaucracy; target group those refugees who have not yet applied for or received status of asylum seeker.

**Expected outcomes:**
To create a working situation for medical staff where they are not hindered by bureaucratic issues

**Achieved outcomes:**
Achieved outcomes supported by already developed system

**Resources needed for implementation:**
Technical infrastructure, contract with interpreting agency

**Availability of the measure:**

http://www.videodolmetschen.com/en/about-us.html

### 5.2. MEASURES TO ADDRESS LANGUAGE AND CULTURAL BARRIERS

The most important obstacles about this issue is that no or insufficient professional interpreters or intercultural mediators are available in health services, and this means long waiting times and not adequate communication of diagnoses and the necessity of treatment. Moreover care providers have received insufficient training in cultural competence and some of them refuse to work with interpreters / intercultural mediators.

**Remote intercultural mediation (via video conference) and intercultural mediators face to face specialized in health care**
(Brussels, Belgium)

**Service/department in charge of the measure**
Intercultural mediation and policy support unit (FPS Health, Safety of the food chain and Environment) and RIZIV (national health insurance institution)

**Description of the measure:**
Intercultural mediators working via videoconference and face to face and intervening in hospitals, primary health care centres and reception centres for asylum seekers.

**Expected outcomes:**
To reduce the negative effects of the linguistic, socio-cultural and ethnic barriers on the accessibility and quality of health care.

**Achieved outcomes:**
Partially. The number and availability of the intercultural mediators involved is insufficient to cover all of the needs

**Resources needed for implementation:**
Funding for the mediators, a coordinating team, training for mediators and care providers, an awareness-raising and promotion campaign, good internet access, the necessary hardware and software. A well-developed soft and hard policy that guarantees that no patient data will become public.

**Face-to face-interpreting**
(Austria)

**Service/department in charge of the measure**
Contact point interpreting services and intercultural care

**Description of the measure**
Already implemented employed interpreters were also provided outside core working times

**Expected outcomes:**
To facilitate communication

**Achieved outcomes:**
Achieved outcomes supported by already existing interpreter pool and search for Arabic interpretersat a very early stage (early 2015)

**Resources needed for implementation:**
Coordinator, budget, training for staff

**Telephone-interpreting**
(Austria)

**Service/department in charge of the measure**
Depends on organization; e.g. contact point interpreting services and intercultural care; hospital director

**Description of the measure:**
Telephone interpreting agency in Salzburg 24hours/day available; following the initiative of the hospital, the agency now offers Farsi/Dari instead of Spanish

**Expected outcomes:**
To facilitate communication

**Achieved outcomes:**
Achieved outcomes supported by already developed system

**Resources needed for implementation:**
Technical infrastructure, contract with interpreting agency

**Availability of the measure**

http://www.videodolmetschen.com/en/about-us.html

**Video interpreting agency contracted**
(Austria)

**Service/department in charge of the measure**
Depends on organization; e.g. contact point interpreting services and intercultural care; hospital director

**Description of the measure:**
Video interpreting covers all languages necessary for health care providers in case of a rare dialect: information on availability interpreter within 15 minutes

**Expected outcomes:**
To facilitate communication

**Achieved outcomes:**
Achieved outcomes supported by already developed system

**Resources needed for implementation:**
Technical infrastructure, contract with interpreting agency

**Availability of the measure**

http://www.videodolmetschen.com/en/about-us.html

### 5.3. MEASURES TO ADDRESS CONTINUITY OF CARE AND LACK OF INFORMATION

Care providers often do not have reliable information on the illness and treatment history of the patient because no adequate systems for the exchange of medical information between member states exist: the result is often a partial and fragmented care provided and the right to health (care) not fully guaranteed.

**Extensive intake at arrival. A process where the nurse consults extensively with the patients shortly after arrival**
(Amsterdam, Netherlands)

**Service/department in charge of the measure**
This measure was implemented by the Coa.

**Description of the measure**
During this extensive intake the nurse collects all relevant medical data. This medical data can be about current health problems or their health history. When patients require immediate care the nurse refers the patients to the appropriate healthcare provider. The Coa expected that the quality of care around and for asylum seekers and refugees would improve when the information of their current and previous health is available. Additionally, the refugees and asylum seekers do not require to first see a GP before they can be referred to the appropriate healthcare provider.

**Expected outcomes:**
To collect all relevant medical data.

**Achieved outcomes:**
The implementation of this measure was successful. Due to the entire healthcare around and for asylum seekers and refugees being based and organized around this intake. Therefore, it is recommended that other organizations would adapt this extensive intake.

**Resources needed for implementation:**
To successfully implement this measure the extensive intake has to be part of the arrival process. This extensive intake is done nationally in the Netherlands. Therefore, it would be a suggestion towards other Member States in this project.

**SIRIA PROGRAMME**
Malaga, Spain

**Description of the measure**
Inter-centre information system on health data and social report of refugees. Completed in first reception centres, in the Spanish case, Centres for Temporary Stay of Migrants, and it may then be consulted and completed throughout the whole transit.

**Service/department in charge of the measure**
Reception centres (no access from public health system centres)

**Expected outcomes of the measure**
Follow-up

**Achieved outcomes**
Partially

### 5.4. MEASURES TO ADDRESS ORGANISATIONAL BARRIERS TO HEALTH SERVICE DELIVERY

Hospitals have limited resources and no supplementary health care services have been organized, so capacity problems seem to occur. This situation may affect the services available for the indigenous population.

**Camp for asylum seekers in Bicske**
Budapest, Hungary)

**Service/department in charge of the measure:**
The government

**Description of the measure:**
Government (Office of Immigration and Nationality) established and run camp in Bicske where asylum seekers get access to healthcare services.

**Expected outcomes:**
The expected outcomes were that the asylum seekers who registered themselves received basic/ primary healthcare services that are entitled to them after registration. In case of need they were referred to secondary health care assistance as well.

**Achieved outcomes:**
More than 400 000 asylum seekers entered the European Union through Hungary, only around 170 000 of them registered themselves, but only 91 000 reached one of the camps. The problem was that most of them just passed through the country hindering their access to health services. Even if they reached one of the camps, it was common that they left before finishing the necessary therapy. However, a number of asylum seekers did access the healthcare system through this institution

**Resources needed for implementation:**
Governmental action that supports asylum seekers in reaching the camp and increase the health care capacity of the in-camp services.

**Availability of the measure:**
Decree 32/2007 (VI.27.) of the Hungarian Ministry of Health, on diseases with public health concerns related to those third country nationals who are staying in Hungary, and are having the right of free movement'

**On-site healthcare service and pharmaceutical aid in transit zones**
(Budapest, Hungary)

**Service/department in charge of the measure:**
Association of Hungarian Primary Care Paediatricians, the Hungarian Baptist Aid and Mikszáth Pharmacy

**Description of the measure:**
Association of Hungarian Primary Care Paediatricians, the Hungarian Baptist Aid and Mikszáth Pharmacy cooperated in providing on-site healthcare services for asylum seekers at the Western Railway Station. It started out with a call for volunteers by Migration Aid which is a volunteer civil initiative to help refugees arriving to Hungary reach their assigned refugee camps or travel onwards. At first, volunteer doctors went on the spot at the Railway Station to aid the asylum seekers in need. There was there neither any professional emergency aid organization, nor governmental organization. Later on, the above mentioned three organizations teamed up to improve the situation. First, they worked in tents, and as a last step they moved into two containers, one worked as an examination room, and one as a pharmacy.

**Expected outcomes:**
To ensure basic healthcare services for those in need in a transit zone.

**Achieved outcomes:**
They could provide satisfactory onsite health assistance and have received a very positive response and trust from the migrants and refugees.

**Resources needed for implementation:**
Professional back up organization, governmental action, training for volunteers.

**Psychiatric and psychological support**
(Lesvos, Greece)

**Service/department in charge of the measure:**
Psychiatrists and psychologists of the island

**Description of the measure:**
The psychologists of the island meet and try to design certain exams necessary for their work

**Expected outcomes:**
To have a common approach and procedure when they try to diagnose mental health problems

**Achieved outcomes:**
At this stage they still work on this procedure

**Psychological intervention guide for direct assistance to migrants and refugees**
(Seville, Spain)

**Service/department in charge of the measure:**
University of Sevilla**;** University Complutense of Madrid; Psychologist of the World organization; Official College of Psychologist in Spain

**Description of the measure**
A guide was created to illustrate psychological reactions present in migratory processes by involving health providers and different institutions.

**Expected outcomes:**
To contribute through a psychological perspective to the current humanitarian crisis.

**Achieved outcomes:**
It was introduced during the current year, thus it has not yet been evaluated.

**Consultation at the GP practice outside of the asylum seeker centers**
(Amsterdam, Netherlands)

**Service/Department in charge of the measure:**
Local health system and asylum centres

**Description of the measure:**
Instead of the GP doing consultation at the asylum seeker centres, the GP does consultation at their own practice.

**Expected outcomes:** The practice can provide better and more equipment and materials. Also the asylum seeker has to make some effort to get to the practice, causing the patient to consider their health instead of easily going to the GP.

**Achieved outcomes:**
With this measure the asylum seeker has more confidence in the healthcare provided. Additionally, the GP has their full arrangement of equipment and materials available. The GP thinks that they are taken more seriously, since the care looks more professionally at a practice than at a asylum seeker centre.

**Resources needed for implementation:**

The GP can implement this measure with the approval of the asylum centres.

**Healthcare protocol for professional teams**
(Seville, Spain)

**Service/department in charge of the measure:**
Psychological care team of "CEPAIM Foundation"

**Description of the measure:**
Some symptoms of secondary traumatization were identified in providers working with refugees and asylum seekers. The psychological care team is working on the development of a protocol to aid those providers.

**Expected outcomes:**

To prevent symptoms related with secondary traumatization and "compassion fatigue" syndrome, which affects the occupational wellbeing of providers.

**Achieved outcomes:**
At this stage they still work on the development of an intervention protocol.

**Resources needed for implementation:**
A well trained professional team is required, as well as adequate facilities.

### 5.5. MEASURES TO ADDRESS LACK OF ORGANIZATION/COLLABORATION BETWEEN SERVICES

Moreover the presence of different NGO's and groups of volunteers in combination with a lack of organization may result in chaos and too little collaboration between the different care providers.

This increases bias and prejudice towards migrant population, since they are regarded to be undisciplined patients who are exploiting and misusing emergency units for problems that are not urgent.

**Warehouse**
(Lesvos, Greece)

**Service/department in charge of the measure:**
The NGO MDM has reported this practice.

**Description of the measure:**
They referred to the well organised warehouse the MDM have with all sorts of clothing which is divided into different sizes. Thus, when the refugees arrive and they are wet they can provide all different clothing and shoes in few seconds as they are easily accessible according to the size of the person

**Expected outcomes:**
To provide warm clothes to people who arrive completely wet with hypothermia

**Achieved outcomes:**
They consider it very helpful

**Resources needed for implementation:**
Clothing from volunteers

**Shelter charity association**
(Budapest, Hungary)

**Service/department in charge of the measure:**
Shelter Charity Association

**Description of the measure:**
Doctors at Shelter Charity Association also received a number of asylum seekers 20-50 cases each day, and they offered primary health services for them in the shelters.

**Expected outcomes:**
To aid those in need to get necessary health assistance.

**Achieved outcomes:**
As more medicine and bandages would have been necessary as it was available. Governmental support and organization would be a way to ensure better services.

**Resources needed for implementation:**
Governmental support in organization and providing materials and assets

**Availability of the measure :**
Available on Hungarian only
**http://www.oltalom.hu/rovat.php?id=47&lang=hu&mid=90**

**Dialogue with the local public social welfare centres**
(Brussels, Belgium)

**Service/department in charge of the measure**
Social services

**Description of the measure:**
Regular concertation (agreement) with the local public social welfare centre on access to health for specific patients and patient groups. Better communication and dialogue could improve the collaboration between public social welfare centres and hospitals.

**Expected outcomes:**
Access to and reimbursement of health care services

**Achieved outcomes**
In a number of cases the granted access created a precedent and improved access for the patient group in question.

**Resources needed for implementation**
An open attitude and a social worker prepared to make the time for dialogue.

**List of all health care providers in the island**
(Lesvos, Greece)

**Service/department in charge of the measure:**
The General Secretariat of Eastern Aegean islands is trying to identify the different NGO's that provide health care to migrants and refugees in order to have a picture of who is doing what.

**Description of the measure:**
They need a list of all health care providers in the island, as volunteers keep changing and doctors do not know the people in the different NGO's

**Expected outcomes:**
Better collaboration and coordination between all the different health care providers.

**Siria programme**
(Malaga, Spain)

**Service/department in charge of the measure:**
Reception centres (no access from public health system centres)

**Description of the measure:**
Inter-centre information system on health data and social report of refugees. Completed in first reception centres, in the Spanish case, Centres for Temporary Stay of Migrants, and it may then be consulted and completed throughout the whole transit.

**Expected outcomes:**
Follow-up

**Achieved outcomes**
Partially

**Multidisciplinary group for the assistance of asylum seeking families**
(Seville, Spain)

**Service/department in charge of the measure:**
Coordination of the program "Reception" of CEPAIM Foundation

**Description of the measure:**
Creation of a multidisciplinary team that assist refugee and asylum seeking families in diverse areas (e.g., psychologist, social worker, lawyer, labour counsellor).

**Achieved outcomes**
We are working on it. There is a barrier in the great amount of existing information that results in disinformation.

**Resources needed for implementation:**
More mediators in all fields; the figure of a healthcare practitioner; training in Arab and intercultural competence.

**Coordination with the healthcare services of the area**
(Seville, Spain)

**Service/department in charge of the measure**
Director of the association "Onna Adoratrices"

**Description of the measure:**
The objective of this measure was the approach and contact with healthcare services in the area (e.g., healthcare centre, hospitals) through social workers. Activities carried out were several meetings and visits so that social workers could know our resources and the reality faced by the women we assist.

**Expected outcomes:**
To be assisted when we had to face healthcare problems with the women we work for.

**Achieved outcomes:**
Social workers led us to new cases referred by the healthcare system. Objectives were accomplished through direct contact with healthcare services and posing our difficulties in healthcare to them. Something that hinder this measure was the staff rotation in healthcare services.

**Resources needed for implementation:**
Resources to offer sensitization and training to healthcare providers.

**Technical roundtable**
(Seville, Spain)

**Service/department in charge of the measure:**
Directorate General for the Coordination of Migratory Policies.

**Description of the measure:**
Establishment of a technical roundtable composed of healthcare counselling centres together with social organizations working with refugees.

**Expected outcomes:**
To identify actors involved in a possible massive reception, specifically targeting healthcare services

**Achieved outcomes:**
The measure was promoted by the organization and supported by the President. There is no homogeneous opinion between the Ministries on the need to rely on the specialized organizations. Refugees' healthcare overlaps with other migrant's healthcare, and there appears to be some reluctance. The lack of financial resources since 2010 is inducing an "avoidant attitude".

**Resources needed for implementation:**
The maximum involvement is stressed**.**

**Cooperation between Slovenian NGO Filantropija and Doctors of the world**
(Slovenia)

**Service/department in charge of the measure:**
Slovenian NGO Filantropija and Doctors of the World

**Description of the measure:**
Despite the numerous persons around Slovenia who participated in health care provision for refugees, the help of different international teams was of a great value. Successful cooperation between Slovenian NGO Filantropija and Doctors of the world resulted in a mobile unit, working at two different arrival centres for refugees. The same model of a mobile unit that is going to work in all units of the centre for asylum seekers is now being established with the aim of providing more comprehensive health care (including psychosocial care) for refugees accommodated there.

**AGREEMENT WITH RED CROSS AND UNHCR REGARDING THE ACCOMPANIMENT AND PROTECTION OF REFUGEES DURING TRANSIT**
(Malaga, Spain)

**Description of the measure**
There is already a protocol (based on the protocol that was drafted for the reception of Bosnian refugees), waiting to be put in place.

**Service/department in charge of the measure**
Malaga Health District

**Migration flows' research**
(Seville, Spain)

**Service/department in charge of the measure:**
Directorate General of the Civil Guard

**Description of the measure:**
Migration Flows' analysis and study. To detect smuggling networks. To detect any inconvenience at reception contexts. To detect border protection systems.

**Regular meetings (every 3-4 months) between social cooperative managers and healthcare authority workers (healthcare and administrative workers)**

**Responsibility:**

Local Health Authority

**Expected outcomes:**
Pathways should be established for access to basic services and administrative practices should be simplified.

**Achieved outcomes:**
The organisation of doctor's appointments and clinical check-ups was a success (this success was supported both by the network of departmental services and the professional experience of the workers involved, including LC mediators).

The administrative problem of limited/missing urgent documents has still not been resolved (the police headquarters does not send GP renewal documents within tight deadlines) and our administration reluctantly accepts "alternative" documents from those indicated by law.

**Resources needed for implementation:**
On the administrative side, the allocation of a GP and NHS registration renewal need to be simplified. On the healthcare side, there needs to be greater sharing with the other healthcare facilities in the ER Region.

**Transmission of reception healthcare data to GPs**
(Reggio Emilia, Italy)

**Responsibility:**
Local Health Authority and Foreign family health centre (CSFS), AUSL Reggio Emilia

**Expected outcomes:**
After an initial period of guaranteed access to basic services at the Centre for Foreigners (dedicated to temporary resident foreigners) lasting a few months, people should be able to register with the NHS and choose a GP; the data (files) from the first doctor's appointments are sent to ensure continuous assistance and healthcare.

**Achieved outcomes:**
The results were not always achieved; firstly, not all GPs were aware of the first reception procedure that took place in clinics at the Centre for Foreigners (assessing essential parameters, migration background, vaccinations, etc); another obstacle to achieving the goals of continuous assistance is the changing opening hours and also the unavailability of LC mediation.

### 5.6. MEASURES TO IMPROVE INFORMATION AND EDUCATION

The lack of understandable information for refugees on the organization of social and health care services further complicates their access to help they may need. This will in many cases be problematic as the refugee's limited health literacy makes it hard for him to navigate the complex health care system. Information barriers are exacerbated by people who pass through and only stay in the region for a short period of time. Also care providers have received insufficient training in cultural competence and may be completely unfamiliar with patients coming from the Middle East.

**Training for refugees on the health care system in Belgium**
(Brussels, Belgium)

**Service/department in charge of the measure:**
Regional authorities who are in charge of integration course

**Description of the measure:**
Trainings on health literacy, preventive health care (vaccination, sexual health, ….), health promotion, accessibility of health care. This training is part of the so-called 'integration courses' newly arrived migrants have to attend.

**Expected outcomes:**
Reduction of health care costs, more prevention.

**Achieved outcomes:**
We don't know whether this goal has been achieved.

**Resources needed for implementation:**
Funding to organize training.

**Response of medical faculties and Faculty for Health Sciences**
(Slovenia)

**Service/department in charge of the measure:**
Faculty for Health Sciences

**Description of the measure:**
Medical faculties and Faculty for Health Sciences that organised groups of students enrolled in courses such as first aid and emergency aid that helped in the arrival camps, where they learned about the situation and gained many working experiences in the field of their study. Moreover, students also organized on their own and offered their help in health care units in arrival camps. As a result, they did not just gain important professional experience, but sometimes also lost many prejudices and stereotypes.

**Supervision and training programme for reception and healthcare workers at the Fanon Centre**
(Reggio Emilia, Italy)

**Responsibility:**
The work has been jointly planned between the Sprar project (Municipality of RE and Coop. Dimora

d'Abramo) and the Local Health Authority. It has been financed with Sprar reception project funds, for which the Municipality is the responsible body, and Coop. Dimora is the managing body.

**Description:**
The supervision/training took the following format:

1) SUPERVISION MEETINGS in small specific groups (15 participants at most), focusing on the supervision of cases involving asylum seekers and beneficiaries of international protection. These meetings were scheduled over 18 months (from January 2013 to June 2014).

The working group was formed of service representatives/workers who were already working, under various capacities (social, healthcare, etc), with the SPRAR project in managing regional integration programmes for beneficiaries.

2) SEMINARS FOR A WIDER AUDIENCE with the goal of raising awareness and engaging/informing regional agencies on the issue of international protection.

**Expected outcomes:**
The acquisition of more knowledge on cultural and historical aspects of refugees' backgrounds and an understanding of relational and psychological dynamics to develop greater expertise in handling the situation; discussion among workers on their views of their work and the meaning they give to what they do in order to form, over time, a multidisciplinary, wide-ranging group (from public, healthcare and private social institutions) that can begin to develop a common view of work and the goals set through collaboration.

**Achieved outcomes:**
For the most part, yes, even though there could have perhaps been more involvement from other services from the outset.

**Resources needed for implementation:**
A more shared approach to planning with other regional subjects; training/supervision alternating between meetings and moments for reflection/exercises online could also be considered (through shared platforms).

**Information for small groups of female refugees from Sub-Saharan Africa**
(Reggio Emilia, Italy)

**Responsibility:**
Volunteer obstetrician and gynaecologist.

The Nigerian English-speaking intercultural mediator was present.

**Description:**
The work was carried out in collaboration with associations/cooperatives that handle the reception of female refugees, mainly from Sub-Saharan Africa.

The information was primarily aimed at healthcare education, STD prevention, contraception and understanding services, with particular reference to the area of WOMEN'S HEALTH.

**Expected outcomes:**
Easier access to services among female refugees who come to the Reggio Emilia region. Support for women in the programme on protecting their own health and preventing unwanted pregnancies.

**Achieved outcomes:**
It is rather complicated to assess whether all the objectives have been achieved in terms of quantity, but we noticed that:

The size of the small group in which you could present yourself and say something about yourself in an atmosphere of respect and willingness to listen helped bring out any needs and individual requests.

Feeling that people are listening to you adds recognition of your dignity, having a positive influence on self-awareness and on individual choices.

Access to services is made easier safe in the knowledge that you will meet people you already know.

It was possible to organise 2 successive meetings a few months apart for a small group of about 10 women. We think this helped form an atmosphere of greater exchange, improved the level of trust and let us elaborate certain content in a more personalised way.

**Resources needed for implementation:**
The available time of the staff involved needs to be acknowledged; a mediator should be present and the programme should be shared with the agency that handles the reception of refugees.

**Mothers workshop: empowerment of women in regard to maternal and child health**
(Seville, Spain)

**Service/department in charge of the measure:**
Psychologist of Sevilla Acoge Foundation.

**Description of the measure**
Development of biweekly workshops to work and talk about issues related to health, education, relationships between parents and children, cultural conflicts (e.g., parents from other countries, minors born in Spain).This kind of group is based on participation and cooperation among participants which have been very useful not only in relation to the objectives of the workshop (i.e., usefulness for people) but also for the parallel activities developed in our organization.

**Expected outcomes:**
To foster the participation of women whose children are being assisted by other programs of the foundation. To create a support group based on trust and respect where women can share their experiences related to health, children's education and problem solving through resources offered by the group. To assist to participants' demands adapting the agenda of the meetings to their requests, recurring to other professionals when necessary.

**Achieved outcomes:**
Identification of needs by the staff and the people assisted by the reinsertion itinerary. Identification of additional needs and the referral of users to other professionals. The constancy in the attendance to workshops and the high number of participants are reasons to think of positive results, besides the positive evaluation of participants. The lack of available resources were the main inconvenience (e.g., people who could not attend to workshops because they could not afford the transport to get to the organization). This workshop has served to incorporate new female users to our services as well as to complete the follow-up of our members who attend to other activities.

**Resources needed for implementation:**
More resources to deepen in a more integral assistance and to make more people benefit from it.

**Inform about the right to free healthcare for migrants in the Andalusian region**
(Seville, Spain)

**Service/department in charge of the measure:**
Association for the Defence of Public Health / Somos Migrantes Platform.

**Description of the measure:**
To request a meeting with de Directorate General for Social Affairs to explain that the regional instruction was not disseminated after the RD16/2012. To counterattack the media campaign on denial of rights to healthcare by visiting the communities to properly inform about this right.

**Expected outcomes:**
To make the positioning of the Andalusian Public Health System known, which ensures free healthcare for migrants and refugees.

**Achieved outcomes:**
The expected results have been achieved. However, public employees' political position was a disadvantage because of the disagreement with this health right perspective.

**Resources needed for implementation:**
The most effective method could be Press releases.

**Briefing on tuberculosis, its treatment and diagnostic methodology**
(Seville, Spain)

**Service/department in charge of the measure:**
Nuria Rojas, responsible for CEAR's social services area.

**Description of the measure:**
A briefing on Tuberculosis was organized at Virgen Macarena Hospital (Infectious Disease Area). Different organizations working with socially vulnerable people were invited. The briefing emerges as a result of some difficulties in primary health care, for example, the different assessments depending on the "mantoux test" medical evaluation.

**Expected outcomes:**
To established a unique and consensual criteria for diagnosing.

**Achieved outcomes:**
CEAR requests health care organizations and professionals to assist and organize the briefing. An informative circular was sent to other healthcare centres by the Infectious Disease Area. The problem still exists.

**Resources needed for implementation:**
It requires substantial time to get the first positive outcomes.

**Health literacy courses**
(Austria)

**Service/department in charge of the measure:**
Human resource management**;** Academy of the hospital trust**;** Nursing schools

**Description of the measure:**
Providing information on health, lifestyle, health care system

**Expected outcomes:**
staff members are able to empathize with refugees and asylum seekers

**Availability of the measure:**

http://www.bpb.de/lernen/formate/planspiele/65586/planspiele-detailseite?planspiel_id=56

**Planspiele**
(Austria)

**Service/department in charge of the measure:**
Human resource management**;** Academy of the hospital trust**;** Nursing schools

**Description of the measure:**
Experimental planning games

**Expected outcomes:**
Staff members are able to empathize with refugees and asylum seekers

**Availability of the measure:**

http://www.bpb.de/lernen/formate/planspiele/65586/planspiele-detailseite?planspiel_id=56

**Giving refugees a map of the healthcare services available in the region (map of the city of Reggio Emilia) during their first doctor's appointment. The map is handed out and explained in the waiting room together with the mediator.**
(Reggio Emilia, Italy)

**Responsibility:**
Foreign family health centre (CSFS), AUSL Reggio Emilia

**Expected outcomes:**
"Basic" understanding and orientation of the healthcare organisation in the city.

**Achieved outcomes:**
We believe the outcomes were positive; the tool should be improved and integrated with a street map of the city (use of public services). The main support still comes from the cooperative instructors.

**Resources needed for implementation:**
On the administrative side, the allocation of a GP and NHS registration renewal need to be simplified. On the healthcare side, there needs to be greater sharing with the other healthcare facilities in the ER Region.

# ANNEX 2

# COUNTRY REPORTS

# Annex 7

# Training Strategy (draft)

Co-funded by
the Health Programme
of the European Union

**SUPPORTING HEALTH COORDINATION, ASSESSMENTS, PLANNING, ACCESS TO HEALTH CARE AND CAPACITY BUILDING IN MEMBER STATES UNDER PARTICULAR MIGRATORY PRESSURE — 717275/SH-CAPAC**

# TRAINING STRATEGY TO DEVELOP REFUGEE/MIGRANT-SENSITIVE HEALTH SERVICES BY TRAINING HEALTH MANAGERS AND HEALTH PROFESSIONALS

This document is part of the project '717275 / SH-CAPAC' which has received funding from the European Union's Health Programme (2014-2020). The content of this document represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

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# 1. Introduction

## 1.1. Why training Health workers

SH-CAPAC project aligns with the recommendations of a global consultation on migrant health, which the World Health Organization (WHO), IOM and the Government of Spain convened in 2010 in Madrid. One of the four priority areas for action was the need to build capacity to develop migrant-friendly health services. The development of health workers' competences to better serve migrants and ethnic minorities is an essential component of building such capacity. There is a need to improve the knowledge and skills of interdisciplinary teams and sectors at various level (national/regional/local) in developing integrated strategies and interventions to ensure access to health care for refugees, asylum seekers and other migrants.

SH-CAPAC Grant agreement states that Work Package 5 will adapt available, relevant training materials from other EU projects focusing on health care for refugees and Specific Health Concerns.

**MEM-TP** was funded by the European Commission's Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) under the 2008-2013 Health Programme. The project (running from December 2013 to March 2016) was implemented by a consortium led by Escuela Andaluza de Salud Pública (Granada, Spain). The aim of the project was to develop, test and evaluate training packages for health professionals with the purpose of improving access to services for migrants and ethnic minorities, including the Roma. The focus was on health professionals in first contact with these groups in primary care settings.

MEM–TP Dissemination Workshop Main Recommendations[1] noted that *tools for **health professionals and managers** to engage in **organizational change, policy revision, and improved community relations** should be included in the future. Improving individual competencies as a strategy needs to be part of a system that wants to improve services towards migrants. Taking a **whole organization approach** is recommended. **Managers and policy makers** should also be targeted, and appropriate additional training material developed for them in the future.*

Participants in this workshop also confirmed that *the concerns raised by the ongoing refugee crisis should be used as a stimulus to arouse interest in the training packages. Economic crises in some countries exposed the structural inadequacies of their health systems. EU Member States are already stressed by the needs of diverse populations. Providing adequate services to a large number of new arrivals is placing further stresses in these countries, as well as their richer neighbors.*

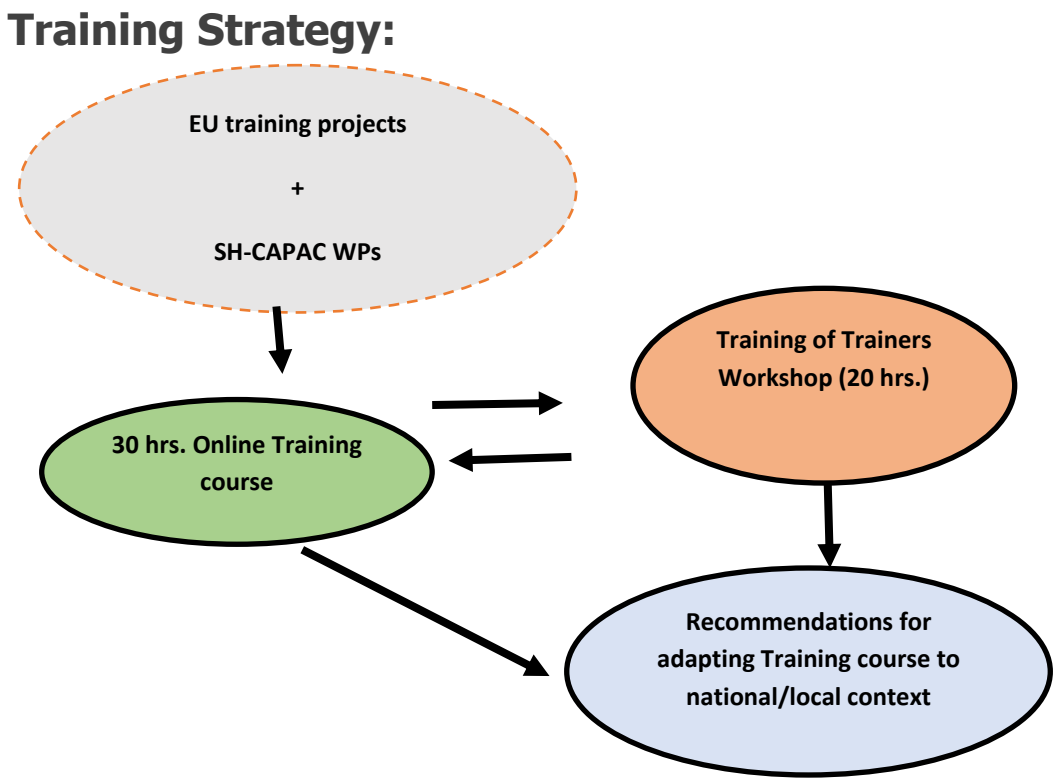
[1] European Public Health Alliance (EPHA) with the support of the Andalusian School of Public Health (2015). Final Report Dissemination Workshop. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada: Andalusian School of Public Health.

**C2ME project** (supported by the EU's Erasmus Lifelong Learning programme) is another project aiming at supporting medical teachers to become more proficient in cultural competence. The project developed and implemented 'Teach-the-Teacher' modules on cultural diversity, as well as a policy for the structural embedding of such training in medical schools. Involving 11 different EU countries, the project aimed to provide knowledge, shape attitudes and build up skills. The results showed that interest in receiving training is high, in particular regarding communication skills. These include adapting communication style to different patient needs, dealing with conflicts arising from different cultural views between care provider and patient, and examining the impact of values and perspectives on the care process.

The **EQUI-HEALTH** action (2013–2016) aims to foster harmonised approaches for improving the access and appropriateness of health services, health promotion and prevention of migrants in the EU. Its training components targeted professionals working with migrants' first reception points. In terms of 'lessons learned' for MEM-TP, the EQUI-HEALTH action confirms the need to target various professionals working with migrants. Training should comprise such elements as overcoming communication problems, identifying migrant sub-groups and overcoming stereotypes. Aiming to show that migrants are ordinary people in an extraordinary situation, EQUI-HEALTH modules include training to dispel myths and false perceptions. In the context of Europe's southern border, training materials should also include such issues as burnout experienced by front liners 'cut off' from the health system, and feelings of loss experienced by migrants. In addition, the issue of communicable diseases was brought up.

Based on this experiences, the SH-CAPAC aims at **building national capacity through training activities for health workers** (health manager, health care professional and administrative staff) in affected countries by implementing training programmes addressed to develop intercultural competences and have a clear understanding of a migrant sensitive health care delivery model, respecting human rights and dignity.

## 2. SH-CAPAC Training Strategy




### 2.1. SH-CAPAC Training Contents

Contents from SH-CAPAC Work Packages have been integrated in the training programme, together with those from MEM-TP training course. Those contents include the **analysis of health challenges and unmet health needs** that the massive refugee, asylum seekers and other migrants flows pose; **assessments of the health care response and public health interventions needed** by the refugee and asylum seeker population; development of action plans for **implementing a public health response and for reinforcing their health systems in order to respond** to the challenges; **promotion and ensuring access** of the refugee, asylum seekers and other migrants populations to health care and public health interventions through a **resource package** to reorient local strategies and plans.

Some relevant conclusions from *WP4 Resource package for ensuring access to health care of refugees, asylum seekers and other migrants in the EU countries* have been considered in preparing the training contents:

- *Culturally sensitive training aimed at improving the coping skills of asylum seekers is required to improve health and deal with the health deterioration and mental health problems frequently observed after arrival.*
- *Insufficient knowledge of the health care system and cultural differences often hamper access to health care.*
- *Linguistic and cultural barriers are systematically identified as one of the major challenges related to access to health care. The impossibility to resolve linguistic*

*barriers makes it extremely difficult to handle cultural barriers that may further impede the care delivery process.*

- *The lack of cultural competence seems to be most problematic in mental health care, making it difficult to provide adequate care for refugees with mental health problems such as PTSD.*
- *Gender issues in the health care have been reported as particularly relevant.*
- *Differences between the medical culture of countries of origin lead to conflicts with MD's.*
- *There is a lack of quality information for asylum seekers/refugees on how to navigate the health care system.*
- *Care providers should be alert to recognize diseases that are uncommon in the receiving countries but may be so in the countries of origin of the refugees and other migrants.*
- *The effects of linguistic and cultural barriers are aggravated by the limited culture competence of many care providers.*
- *The lack of understandable information for refugees on the organization of social and health care services further complicates their access to help they may need.*
- *To sensitize administrative and healthcare staff of healthcare centers in order to increase their knowledge and empathy skill so to offer a better assistance to users.*

Following MEM-TP recommendations, SH-CAPAC has reinforced contents on sexual and reproductive health (SRH) and sexual violence (SV) as vital elements in the health status reports. SV is a specific reason for claiming asylum and as in international humanitarian crisis settings; they are considered priority health concerns which requires specific screenings and interventions. *Make it Work!*[2] Training manual have been used for this purpose.

### 2.2. SH-CAPAC Training Course

SH-CAPAC training activity supported on the EASP virtual campus, aims to **addressing the specific needs of health care services in the EU to improve access and quality of health services for migrants, with special focus on refugees**.

Training delivery is a **30 hrs. online training course in English** supported by Andalusian School of Public Health (EASP) online campus in Moodle, offered in 5 modules over 5 weeks. The virtual training course will be open to participants from **September 26th to October 31st, 2016.**

Following recommendations from MEM-TP Project's evaluation on training programs[3], health care organisations should ensure that staff at all levels improve awareness, acquire knowledge

[2] Frans, E. and Keygnaert, I. (2009) Make it Work! Prevention of SGBV in the European Reception and Asylum Sector. Academia Press, Ghent.

[3] Chiarenza A, Horvat L, Ciannameo A, Vaccaro G, Lanting K, Bodewes A, Suurmond J. (2015). Final Report Review of existing training materials. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Reggio Emillia, Amsterdam: Andalusian School of Public Health, AYSL of Reggio Emilia, University of Amsterdam.

and build capacity to address issues related to access and quality of care for refugees, asylum seekers and other migrants and vulnerable groups. It is suggested a multi-professional, cross-hierarchical general approach at the beginning of training addressing the issues of access and quality of care delivery. According to the data, this would set the context for an understanding of the complexity and relevance of such training from many different perspectives.

Participants from a multi-professional audience from different regional contexts will share specific contents, while other content will be restricted pending on the professional's profile. Heterogeneity of participants' profiles and experiences adds diversity to the interaction in the forum by bringing different perspectives.

The Training program should embed a clear focus on outcomes for healthcare professionals as well as patients, and health care organisations. Therefore the Training has been designed to meet the training needs of three different profiles:

- Health Managers: it is essential to involve this profile to support organisational change by linking the training programme to policies and procedures, actions and service performance assessment.
- Health Professionals: clinical staff such as doctors, nurses, midwife, social worker, psychologist.
- Administrative staff: non-clinical staff who are involved in direct communication with patients and their relatives.

Learning needs differ according to type of role, years of experience and personal skills. Therefore a flexible approach is developed to meet the needs of the target participants which includes **specific training pathway** for health manager (**HM),** health professional (**HP**) and administrative staff (**AS**) and a two-level training content: basic (**B**) and advanced (**A**).

The training consist of a balanced mix of theoretical and practical trainings, therefore there is a mixture of information giving by the trainer and interactive online activities and group exercises. Discussion sessions shall be organised in a participatory way, promoting the exchange of views and feedback from participants.

The teaching and learning methods focus on:
- Theoretical presentations,
- Problem based learning and
- Experiential and analytic self-reflection.

Learning activities include diverse and interactive educational methods to allow participants to explore mutually challenging work situations, to frame together problems and solutions and consolidate networks. The proposed activities will focus on analysis of case studies (drawn directly from experience) and interaction of participants (through discussions in forum), based on personal experience and local examples.

The evaluation plan includes the following assessment tools meant to evaluate the learning progress of participants:

1. Pre-post questionnaire *(assessing differences in knowledge in comparison to the start of every module)*;

2. Learning activities *(in every module);*

3. Written feedback from participants in forum *(at the end of the course)*;

4. Quality and satisfaction questionnaire *(at the end of the course)*;

5. Follow up online written feedback from participants in course forum after 4 weeks *(by November 2016)*.

6. Follow up proposal to be developed after six month period.

The evaluation report on the training course will include a set of recommendations and lessons learnt to implement the adapted training courses at national level.

### 2.3. Training of Trainers

To implement the training strategy at national level, the training program and contents are meant to be adapted to national/local context. A **Training of Trainers Workshop** will be held in **September 15th- 16th (Granada, Spain)** to assist training national managers and trainers in the adaptation process. The ToT will be organised in collaboration with the Health authorities from the participating Member States.

Objectives:

- To disseminate the training contents of the Online training course.
- To train national trainers who will support the training implementation.
- To assist national trainers who will implement the training at national level in the countries selected.

The training programme will be adapted to the specific situation of each country, migrant entitlement to healthcare, health system characteristics, health managers, professionals and administrative staff's training needs, etc.

A *training needs questionnaire* to assessing participants' training needs before the course starts, and learning outcomes after the training, will be available for the adaptation of contents to national and local context.

To ensure the replication and sustainability of the training, the national training courses should be implemented in collaboration with the national health and education authorities responsible for the capacity building of health professionals and service providers. Other stakeholders may

be involved, as health insurance organisations, European and national health professionals associations, NGOs, etc.

The workshop will take place in Andalusian School of Public Health at Granada. The working sessions consists in:

- Explaining the training contents with media complements (PowerPoint slides, videos).
- Identification of possible barriers and facilitators for the adaptation of the training content and format to the national/local context.
- Additional contents on teaching methodology and adult education.

The training is conceptualized as a "peer-to-peer training". Those professionals who already have experience and training in health care directed to migrants and refugees will transmit to their colleagues the theoretical contents and, above all, the effective way off applying the approach to their daily work. Therefore it aims at involving professionals with experience in managing Health care devices and programs, and "front line" Health professionals working with migrant population. They can transmit not only the theoretical knowledge but also the effective daily work.

To participate in the Trainer of Trainers Workshop priority will be given to professionals with ability to understand and explain the content of the training courses. English language knowledge and skills in order for the trainees to be able to interact with other trainers and basic use of internet, e-mail and word processing software. Time to adapt, develop and implement the training program in the country of origin is needed.

The **Training of Trainers Workshop** includes an evaluation questionnaire on the training contents and identification of barriers and opportunities. This questionnaire will be used to develop recommendations for implementing the trainings at national/local level.

### 2.4. Authors, tutoring team and support staff

Training contents have been developed by a team of experts from the SH-CAPAC project. The Consortium is comprised of the following seven institutions:
• Escuela Andaluza de Salud Pública (EASP) (Spain),
• Azienda Unità Sanitaria Locale di Reggio Emilia (Italy),
• Trnava University in Trnava (Slovakia),
• Jagiellonian University Medical College (Poland),
• International Centre for Reproductive Health/ University of Ghent (Belgium),
• Academic Medical Centre/ University of Amsterdam (The Netherlands),
• University of Copenhagen (Denmark).

The Consortium includes relevant centres with a long and complementary experience in migrant and ethnic minority health care as well as in the design and development of training activities directed at professionals and health care providers and oriented to improve health care quality and promote accessibility for these population groups. Three of them, the Andalusian School of Public Health (EASP), the University of Copenhagen and the Jagellonian University have

previous experience of collaborative work as members of the Consortium which conduct the European Master of Public Health (EUROPUBHEALTH) and have a formal agreement of collaboration.

They were joined by the Azienda USL of Regio Emilia, Trnava University in Trnava and the Academic Medical Centre/University of Amsterdam in the consortium that implemented the project for the EC sponsored project for development and testing of training materials for improving quality of health care for migrants and ethnic minorities (MEM-TP). The International Centre for Reproductive Health/University of Ghent, with ample experience in participating in European projects on Sexual and Reproductive Health and Sexual Violence has joined the Consortium presenting this proposal.

The authors, tutoring and support staff is a multidisciplinary team of professionals from the areas of Primary care, Psychology, Political Sciences, Economics and Sociology. Experts in Epidemiology and Public Health, Migration Policies and Legislation, Health Promotion in Health Care, Education and Social Contexts, Gender and Health. Research areas: migration and health, intercultural diversity, training of trainers methodologies, access to health care, social and gender determinants of health and health inequalities, economic crisis and health, human rights perspectives, unaccompanied minors, mental health, body and gender diversity, citizen participation in health, sexual and gender diversity, qualitative research methodologies, and ethics.

## 3. Training Strategy timeline

| | |
|---|---|
| January | • Setting up a Working Group led by EASP Team |
| February-March | • Find priorities for the outline of contents focused on improving access and quality of health services for migrants, with special focus on refugees |
| April | • Discussion on outline of contents (6th Trnava, Slovakia)<br>• Design the Training strategy<br>• Develop the Course guideline |
| May-July | • Develop the training programme, contents and formats of the training materials and Evaluation tools |
| June | • Regional awareness seminar (Workshop) to facilitate implementation of the training strategy (16th-17th Reggio Emilia, Italy) |
| June-July | • Develop the contents of the 20 hrs. Training of Trainers Workshop |
| September | • Training of Trainers Workshop and Report (15th-16th Granada, Spain) |
| September-October | • Development of the online training course (26th September-31st October, virtual campus EASP) |
| November | • Evaluation of the online training course |
| December | • Work Package 5 Report |

## Annex "Training course programme and pathways"

| Modules and Units | Pathway HM | | Pathway HP | | Pathway AS |
|---|---|---|---|---|---|
| **Module 1. Context** | **B** | **A** | **B** | **A** | **B** |
| **M1.Unit 1.** Definitions. Framework of Migration and Asylum in EU. Asylum claims and trends. | | X | X | | X |
| **M1.Unit 2.** Socio-cultural context of refugees and migrants' health | X | | X | | X |
| **M1.Unit 3.** Determinants of health among refugees and migrants Health risks before, during and after the journey | X | | | X | X |
| **Module 2. Strengthening institutional capacity to organize the response** | **Pathway HM** | | **Pathway HP** | | **Pathway AS** |
| | **B** | **E** | **B** | **E** | **B** |
| **M2.Unit 1.** Framework for coordination. Intersectoral collaboration. | | X | X | | X |
| **M2.Unit 2.** Assessment of health challenges. | | X | X | | X |
| **M2.Unit 3.** Planning and implementing public health response and actions | | X | X | | X |
| **M2.Unit 4.** Knowledge and information base for migrant health | | X | | X | X |
| **M2.Unit 5.** Health policies and provision of health services in EU | | X | X | | X |
| **Module 3. Capacity building for migrant sensitive Health systems** | **Pathway HM** | | **Pathway HP** | | **Pathway AS** |
| | **B** | **E** | **B** | **E** | **B** |
| **M3.Unit 1.** Diversity sensitive health care principles. Sensitivity and awareness of culturally diverse backgrounds | | X | | X | X |
| **M3.Unit 2.** Health care model and accessibility | | X | X | | X |
| **M3.Unit 3.** Cultural and health mediation | X | | | X | X |
| **M3.Unit 4.** Communication skills Addressing sensitive issues | X | | | X | X |

| | | | | | |
|---|---|---|---|---|---|
| **M3.Unit 5.** Caring for the caregivers | X | | X | | X |
| **M3.Unit 6.** Health prevention and promotion | X | | | X | X |
| **Module 4. Specific health concerns** | **Pathway HM** | | **Pathway HP** | | **Pathway AS** |
| | **B** | **E** | **B** | **E** | **B** |
| **M4.Unit 1.** Mental health | X | | | X | X |
| **M4.Unit 2.** Sexual and reproductive health | X | | | X | X |
| **M4.Unit 3.** Chronic diseases | X | | | X | X |
| **M4.Unit 4.** Communicable diseases | X | | | X | X |
| **M4.Unit 5.** Violence | X | | | X | X |
| **Module 5. Vulnerable groups** | **Pathway HM** | | **Pathway HP** | | **Pathway AS** |
| | **B** | **E** | **B** | **E** | **B** |
| **M5.Unit 1.** Victims of trafficking | X | | | X | X |
| **M5.Unit 2.** Children refugees and unaccompanied minors | X | | | X | X |
| **M5.Unit 3.** Undocumented migrants | X | | | X | X |
| **M5.Unit 4.** Elderly | X | | | X | X |
| **M5.Unit 5.** Women | X | | | X | X |
| **M5.Unit 6.** LGTB | X | | | X | X |